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Pharmaceutical entanglements

An exploration of the effects of stimulant medication in children's lives

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Pharmaceutical entanglements: an exploration of the effects of stimulant medication in children's lives

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Abstract

Pharmaceutical Entanglements aims at exploring the complex and local interactions between stimulant medication, children using it, and other human and non-human actors which are present inside the classrooms of two neo-Catholic high-income schools in Santiago, Chile. Although much has been written in social sciences about the interactions between stimulant medication and children, most of these accounts have approached this topic neglecting the practicalities arising from such an encounter. Rather than providing an abstract or theoretical description of how the medical apparatus is put into use to control deviant behaviour by children, this thesis centres its analysis on how, in practice, these interactions are more nuanced and open-ended than commonly is described.

To provide an insight into how these interactions take place in the everyday life worlds of actual children, *Pharmaceutical Entanglements* is based on an ethnographic experience that took place during 2015 in two schools located in the East Side of Santiago, Chile. As discussed in this thesis, location is an essential element to be considered if one is to understand the trajectories that the medication can undergo. As I argue during the six chapters composing this thesis, the socio-material setting where the medication unfolds plays a decisive role in how different actors can produce an interplay that can lead to strengthening the medicated child's sense of agency, or can lead to its collapse.

Importantly, this project does not position itself in principle either as opposing the use of stimulant medication or encouraging it. Rather, it tries to fill a gap in the social sciences literature on the topic by updating the discussions about potential dialogues between life and the social sciences, encouraging the field of childhood studies to embrace up-to-date theories in social sciences, and producing new examinations of how children deal with, and make use of,

stimulant medication and psychiatric labelling. In that sense, this investigation does not dismiss traditional concerns about the potential perils and hazards linked to the use of pharmaceutical drugs. Rather, it centres its focus on the lives of medicated children and their interaction with teachers, staff members, peers and others, animating specific and local uses and trajectories for the medication as they constantly attempt to establish coordinated dynamics with those around them.

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Acknowledgments

I learned that writing a thesis is a process filled with contradictions. Its production reflects the result of a solitary struggle, a constant facing and dealing with oneself and with one's own ideas and preconceptions of the world. In that sense, writing a thesis mirrors an inner process, where the author's intellectual curiosities and inclinations are constantly put to the test in a relentless battle against oneself. But at the same time, it is impossible to separate its making from the substantial contributions, discussions and debates held within the intellectual communities and social atmospheres attended by its author. In that sense, writing a thesis is undoubtedly a solitary endeavour, but it is never an isolated one. It has been hard and exhausting, but incredibly fulfilling. And in the writing of this thesis, I have so many people to thank.

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Introduction

In the final section of his impressive 800 page book about the history of childhood in Chile, renowned Chilean historian Jorge Rojas (2010) argues, in a contemplative tone, that research conducted in Chile has mostly neglected specific areas of the social world. He later develops this argument by mentioning that what seems to be lacking in the national context is interest in engaging with children's lives and problems as they live and experience them on a daily basis, especially in relation to some areas that have been dramatically transformed over the last decades. Among these it is possible to mention the transformation in family life as the result of the emergence of new forms of parenthood and motherhood, the societal changes that are being pushed because of the processes of globalisation and, finally, the profound modifications in children's lives that are being spurred by the introduction of new technologies and knowledge.

This thesis aims precisely at engaging with one of the most polemical faces displayed by the last of the above mentioned: the modification of our own understanding thanks to ideas and notions advanced by biomedical knowledge, and the possibility to intervene in ourselves through the use of pharmaceutical drugs. More specifically, this thesis is an investigation of children's lives, and how they intertwine with stimulant medication in the classrooms of two schools located in Santiago, Chile. My interest in this topic is fuelled by the increasing exposure that attention-deficit/hyperactivity-disorder¹ has received in Chile since the 1990s, which has contributed to the recent and growing interest and the polemics linked to the use of stimulant medication, which seem to have multiplied during recent decades.

The interest in these topics has become more visible, as it has found its way to newspapers and magazines, thanks to individuals and collectives opposing the use of pharmaceutical drugs and questioning the validity of the disorder. From media articles (Becerra, 2013b; Galvez, 1995a; Ramírez, 2013) to the Government (Ministerio de Educacion (MINEDUC), 2009; Ministerio de Salud (MINSAL), 2008), as well as national experts on the subject (Buttinghausen G et al., 2011; Roizblatt, Bustamante, & Bacigalupo, 2003; Rojas Navarro, Rojas, & Peña, 2017; Vicente et al., 2012), it seems

¹ From this point on, I refer to Attention-Deficit/Hyperactivity-Disorder as ADHD

that ADHD has become a matter of national concern, and so has the use of stimulant medication. However, and in line with Jorge Rojas' concerns, few explorations have been conducted about this topic focusing on children, emphasising their role and views about being medicated (Rojas Navarro & Rojas, 2015), and none have approached the topic as I propose to do it here: by centring on practices.

I propose a different approach to the topic because I believe that debates around the use of pharmaceutical drugs by children lack, precisely, children's insights, reflections and experiences, and that a window to such data can be opened by approaching the subject differently. Given the actual and increasing controversies, it seems urgent to introduce them into the debates by highlighting, according to their own words and experiences, how stimulant medication can be used to different ends. But this makes it necessary to hold back the assumption — under the idea of the child's best interest — that intrinsically there is something morally wrong in putting together children and pharmaceutical drugs, no matter what the circumstances. Contrary to what is commonly reflected with a certain yearning by most social analyses when it comes to children's interactions with biomedical by-products, and especially when it comes to mental health, children's life worlds are not restricted to inhabiting an idealised vision of Nature. Affrica Taylor has recently noted that children's common worlds — the worlds they share with other human and non-human beings on daily basis — are 'not separated, pure and natural utopic spaces. They are mixed up worlds in which all manner of things co-exist—including the manufactured and the organic, the living and the inert, entities and forces, and humans young and old.' To this, she adds that 'humans are not the only ones making or assembling the common worlds—doing the common worlding. Common worlds are produced through the heterogeneous relations between all of these things' (2013, p. 80). Instead of bluntly rejecting all potential interactions between medication and children, this thesis proposes to accompany the everyday lives of children as they co-exist with the medication, either because they are under pharmacological treatment, or because they share the daily activities in the classroom with medicated children. This is inasmuch as I consider, along with others, that children are hybrids, products of ongoing dynamics of assemblages (Kraftl, 2013; Malone, 2016; Prout, 2005, 2011; Taylor, 2013; Taylor & Blaise, 2014), and ontologies are relational, and therefore can be multiple and

divergent, as things come into being through encounters in the process of relating (Mol, 2002; Thompson, 2005).

Instead of thinking about the child as a closed entity, clashing with other entities and forces such as the stimulant medication, the window I opened begged for a different question: what possibilities open to our analysis by considering children as articulated in relation to their everyday interactions, including those involving stimulant medication? Also, if the process of creating life worlds relies on interactions and processes of assemblages, would it not be necessary to think that experiences and outcomes of using stimulant medication would vary according to the other actors co-existing in different settings worldwide? Following these questions, this thesis presents the results of an ethnographic research that was conducted over 8 months in two schools located in a high-income borough of Santiago, Chile. The ethnographic process took a different methodological approach to most research about the topic conducted in Chile, mainly because it did not rely on adults' ideas about what stimulant medication does, nor did it ask adults to try to remember their bad experiences with the stimulant medication. I ventured to obtain this data first-hand, and stay open to being surprised by what I could encounter when children become not only objects that need to be taken care of, but also actors constantly shaping their own life worlds. But their role is not only to create a world of their own, as they also participate in arrangements with others that lead them to inhabit common worlds that, with more or less success, they manage to navigate. This does not imply that stimulant medication was, to my consideration, something good for children to use. But neither did I want to set as a starting point the idea that psychostimulants were essentially bad. That is why this research is about those shades of grey that run in between the two reductionist approaches that are so commonly encountered in social science about this topic. It is about the nuanced grey area, because after spending time with medicated children I found out that this is where, most of the times, interactions take place, worlds are constructed, and realities are experienced.

Can stimulant medication do harm to children? Yes, it can. I build upon this during different sections of this thesis, especially in Chapter 5. Can stimulant medication do something else beyond doing harm? Well, of course. However, this seems to be

overlooked by most social science accounts inspired by the medicalization thesis. What else can stimulant medication do? Several things, as they proved not to be auto-effective, that is, there is room for the medicated child to entangle with the medication and make use of the bodily sensations and emotional articulations that can be created with and thanks to the medication. As described by Jeremy Green, medications are portals that allow us to understand connections between sociohistorical moments and individuals (2008), and the subsequent struggles that this might entail. Therefore maybe it would be wise to think about the rise in consumption of stimulant medication in Chile not only in terms of coercive attempts to control and deal with children inside schools, but also looking beyond that. Maybe the rising prevalence of ADHD does not reveal only desperate attempts to label and control any signs of deviance from the norm in children's behaviours, but also attempts to provide aid through medical interventions by stretching the limits of the diagnosis, as is commonly done in Chilean public mental health centres (Cuthbertson, 2015). I discuss these matters in Chapter 3, when explaining how and when ADHD and stimulant medication became widespread in the Chilean context. Maybe we can be surprised by listening and following children's interactions with the medication in their everyday lives.

The focus on thinking differently about the role of stimulant medication — and pharmaceutical drugs in general — in children's lives helps to broaden the spectrum of analysis commonly used in sociological accounts of consumption of medication by children, particularly when this process is linked to mental health disorders. For a long time, this topic has been dominated by the extraordinary influence of the medicalization thesis, and its analytical emphasis on examining this relation in terms of power, control, surveillance and authority (Nye, 2003). Although this body of work provides a significant backdrop for my own research as I share some of their concerns, I must agree with those arguing for the need to look past it, mainly because as an analytical tool its use seem to have grown blunt (Davies, 2006), no longer proving a proper analysis of underlying dynamics but only a description of different situations (Rose, 2007) and, in the long run, because the social world which this theory was meant to analyse has changed dramatically over the years (Nye, 2003) which makes it necessary to update our questions and search for new answers.

The need for alternative approaches prompted me to search outside traditional accounts in childhood studies. Although alternative bodies of work have thought differently about the roles of medications for decades (Martin, 2006; Van der Geest & Whyte, 1989, Van der Geest, Whyte, & Hardon, 1996), their efforts seemed to have had little to no repercussions when it comes to studying children. Apparently, this is in part because childhood studies are still too strongly influenced by modernist sociology, with its binary divisions of the social world (Lee & Motzkau, 2011; Prout, 2005; Prout, 2011). Hence, for these modernist accounts, it is either the child or the medication that is the one acting and in control. Even more, the introduction of the medication is considered to cancel the child's capacity to act freely, to function in an autonomous way, as she would become tainted, corrupted by the medication. But medications can act differently, as has been revealed time and time again. They can act to produce novel agencies, new ways of inhabiting and acting in the world (Gomart 2002, Gomart 2004). And if they can do that in experiences with adults, can they do the same when it comes to children? To explore such a possibility requires changing widespread social assumptions about what children are, about their 'closeness to nature' and 'purity', ideas which are now part of an extended western social imagination of children (Prout, 2005) and to introduce ideas about individuals which have had difficulty reaching the field of childhood studies, ideas that have been pushed forward in social and life sciences in fields such as Science and Technology Studies (i.e. Cussins, 1996; Law & Mol, 1995; Mol, 2002; Pickering, 1995, 2013; Thompson, 2005), social science's approaches to biomedicine (i.e. Behrouzan, 2016; Biehl, Good & Kleinman, 2007; Bush, Trakas, Sanz, Wirsing, Vaskilampi, Prout, 1996; Rose, 2003, 2013; Tausig, Hoeyer & Helmreich, 2013; Vidal & Ortega, 2017), in the Anthropology of Pharmaceuticals (i.e. Ecks, 2013; Etkin, 1988; Petryna, Lakoff & Kleinman, 2006; van der Geest, 1996; van der Geest & Whyte; 1989; van der Geest, Whyte & Hardon, 1996) and by a small, yet growing community of scholars and academics working in early childhood studies who have set forth a research agenda trying to bring some of the theoretical developments made in other fields in order to enrich their understanding of childhood (e.g. Prout, 2005; Taylor, 2013; Taylor & Blaise, 2014).

It is from this point that this thesis departs. Starting from the consideration than more can be expected of children than just striving to achieve their potential by the time

they become adults, the interrogations I follow embrace the potentialities linked to the idea that children are agentic creatures, constantly engaging in the task of building, inhabiting and sharing common worlds with other actors. In this process, children meet stimulant medication in the context provided by schools which have a particular history, as they share a common background that relates them to new Catholic movements embraced by the Chilean elites. Their influence is revealed in the schools through the diverse expectations that such locations place upon children, of how they should behave and in what kind of women and men they should turn into, as it is also revealed in the expectations the schools have in how stimulant medication should improve children's lives, and the ways they inhabit the schools' premises. After all, schools are institutions where power dynamics are in order, and where control — and sometimes docility — is pursued, with stimulant medication used to fulfil such purposes. Yet, the ways in which the schools intend medication to be deployed are not necessarily the same ways in which it actually happens in children's daily lives, as I will discuss in this project. Children can be recalcitrant, as they can use the medication to be divergent just as much they can use them to follow their teacher's instructions. Again, this thesis argues that although stimulant medication undoubtedly has an impact on children's bodies, its effects are not auto-effective and seem to require a series of actions by the child in order to be put into action. Otherwise, its influence seems to be experienced as uncomfortable and hazardous, to say the least. However, as an open-ended, complex and multi-determined process, the effects of the medication seem to have more than just one end.

The structure of the thesis

This thesis is divided in six chapters. Taking into consideration the idea that the uses and effects of psychostimulants are not homogeneous worldwide, but, rather like any other medication, its efficacy and power is closely linked to the sociocultural and material setting where it is being deployed (Etkin, 1988; Petryna, Lakoff & Kleinman, 2006), just inasmuch as understandings of ADHD also emphasise different signs depending on the location (Rojas Navarro, Rojas & Peña, 2017; Singh, 2007; Singh, 2012), this thesis' arguments follow a similar path. Considering this, I followed a broad-

to-specific strategy. Each chapter transits from a wider view of the location and from more global problematics, to more local and specific understandings. Thus, the intention behind the sequence of chapters is to walk the reader from a global idea of ADHD and from the common assumption that stimulant medication works homogeneously everywhere, to more local and specific understandings. From a national view of ADHD, to that shared in the wealthiest boroughs of Santiago, to the one displayed in Chilean elite schools to, finally, that exhibited and expressed in the classrooms through practices held daily by medicated children and other actors sharing their common worlds, entangling with them on a daily basis.

Chapter 1 starts by locating the topic of children's use of stimulant medication in social science literature. It proceeds from the most authoritative and renowned accounts, namely the medicalization thesis, displaying their strengths but also their numerous shortcomings that make it necessary to search elsewhere in order to produce new and distinctive approaches to the subject. Therefore, other fields of inquiry are explored, attempting to constitute a body of work that does not exhibit the same limitations arising from the medicalization thesis, in particular its profound humanism, its tendency to position children only as objects produced by external social dynamics, and its distrustful relation with the biological apparatus.

Chapter 2 is the result of a long process of research about the historical, sociocultural and epidemiological data available in Chile about stimulant medication consumption by children. As mentioned earlier in the introduction, the main argument this chapter tries to demonstrate is that both ADHD and the uses and effects of stimulant medication follow idiosyncratic paths, in the sense that sociocultural and material elements trace particular histories for how ADHD is understood, and for the rising use of stimulant medication. By following such a rationale, this chapter tries to understand the current prevalence rate of ADHD, and the increment in the use of pharmaceutical treatments as the main way to deal with symptoms linked to ADHD. But also, this chapter reveals how interest in the topic in Chile has been shown in social sciences almost exclusively by analyses inspired by the medicalization thesis, and excluding children from any kind of consultation regarding the topic. Despite all the hype in

relation to the topic of children's use of psychostimulants, there seems to be little to no interest in children's views and experiences when debating the topic.

Chapter 3 starts from the consideration that children need to be included so new understandings can be crafted. Therefore, this is a chapter about the methods used in this thesis in its attempts to produce something new that can provide some insights beyond the scope of the traditional accounts. In this chapter I discuss my research questions, the methods used, the sampling process and the ethical concerns. It also explains 'how' and 'why' this research was conducted, and how the different actors were considered during the research process, considering the relevance given to involving children into the research.

Chapter 4 places the reader in the location where the research was conducted. But in order to understand the particular understanding that ADHD and stimulant medication have in such a setting, it is crucial to first describe what these schools are like, since their background and history provide significant clues guiding the use of the medication and the evaluation of its efficacy. First, this chapter describes the spatial location of the schools, as their whereabouts reflect the background of children attending them, the expectations of their families about the pedagogical process, and the configuration of the guidelines governing how interactions take place inside their premises. Being schools linked to the Chilean elites with strong ties to a specific form of Catholicism, this chapter describes how these influences find their way to the crafting of pedagogical and educational practices and command what the school refers to as 'the training of the soul' of children. However, children engage in manifold ways with the disciplinary techniques and pedagogical practices, sometimes giving up to them, but at other times growing recalcitrant. By analysing different stories and excerpts from my fieldwork, I illustrate how these processes take place, and how stimulant medication is put into action by teachers to try to accomplish certain identities.

Chapter 5 zooms in from the schools to the specific setting provided by the classrooms. As I argue, the sociomaterial setting is central to understanding the different forms in which stimulant medication can entangle with children and the other human and non-human actors present in such a location, constituting fragile yet dynamic assemblages

that produce alternative ways in which the medication can be put into action by the medicated child. Using several excerpts from the data collected during my ethnographic process inside the schools, I present the reader with two different forms in which these *pharmaceutical entanglements* can take place. At times, the results can be the strengthening of the medicated child's sense of agency. At other times, it can lead to feelings of discomfort and uneasiness. The aim of the chapter lies precisely in walking the reader through these different possibilities, as it tries to provide a description and explanation of how these different entanglements come to be.

The last chapter of the thesis, Chapter 6, looks back at the findings of the thesis, placing special attention on four key themes that became evident to me while conducting the fieldwork and analysis of the data. The four key themes are 'ADHD, psychostimulants and representation of children in Chile'; 'the sociocultural embeddedness of psychiatric diagnosis and medication'; 'new ways to think about agency in childhood studies'; and 'pharmaceutical entanglements'. By formulating and analysing these 4 categories, I intend to clarify the main findings of this thesis. After that, I provide a conclusion where different limitations to my project are discussed, and where potential future projects are envisaged.

Chapter 1

Of children, stimulants and subjectivities: an approach to the literature on children's use of stimulant medication

An overview of the 'medicalization thesis'

The many shapes of the medicalization of childhood: the use of medication and the menace of social control.

Time to move forward: a critical appraisal of the medicalization thesis

Between enabling and constraining: the shifting roles of medication in a person's life according to social scientists

What about children? Stimulant medication, children's experiences and the question of agency: new perspectives

Conclusions

In this chapter I aim to present the major trends and key discussions in which this research is embedded. By doing so, I intend to highlight the central ideas, theories and bodies of work that were useful and served as an inspiration in shaping and tackling the main objective of my research. Also, I aim to reveal how the very ideas that served as a basis for my research present relevant shortcomings which I attempt to overcome in different ways, combining aspects of different fields of work, to address my research question.

My research is centred on exploring the interactions, uses and effects that can arise out of children's consumption of stimulant medication in the classrooms of two religious schools located in a wealthy borough of Santiago, Chile. I underscore the specific context of the schools, as I stand opposed to the idea that lives of millions of children worldwide, and their experiences with medication, can be understood as identical, despite the divergent sociomaterial contexts where they are located. Contrary to this idea, I argue that by locating ourselves in a different standpoint it

becomes possible to observe and study the rich and nuanced interactions that take place when children and medication meet.

With this in mind, this thesis proceeds to craft a novel standpoint that might allow us to shed some light on something that, so far, has not been problematised properly. Until now in social sciences, the topic of children's interactions with pharmaceutical drugs has been almost exclusively the terrain of the medicalization thesis. By this, I refer to the body of work that has explored and criticised the growing trend of using biomedical knowledge to explain and intervene fields of human life that were previously understood under different terms. I intendedly decided to use the spelling 'medicalization thesis' as it is the more frequently used in specialised and lay literature about the topic, prevailing over other potential spellings such as 'medicalization theses', or 'medicalisation'.

It is not my intention to dismiss the relevance of the medicalization thesis. However, although its relevance and influence are undeniable — serving as an important backdrop for my own research — this theoretical standpoint exhibits significant shortcomings that I explore in this thesis. To produce an approach that can thoroughly explore the subtleties arising from the entanglements between children and medication in specific locations, I start by giving an overview of the three bodies of work this research drew inspiration from. This overview has two objectives. First, to make explicit the existing points of agreement between these frameworks and my own research and, second, to reveal my concerns and disagreements with certain aspects of these theories, especially after considering how their framing of this interaction flattens the problem, obstructing the possibility of thinking that anything new could emerge out of these entanglements.

That is why I aim to move away from these bodies of work. I argue that a new approach is needed, one that can better suit the interactions between children and medication by dealing with the complexities that this relationship entails. I suggest that more nuanced approaches to this subject are needed, approaches which can be reflective upon how multidirectional relations take place, focusing on how these processes may enable new phenomena to arise and new features to come into being, both of which are reflected in how children's everyday lives take place in the classroom.

My goal for this chapter is three-fold.

First, I intend to give the reader an overall understanding of how the social sciences have previously approached topics and research which might resemble my own. I argue that probably the most commonly used trend in social science to understand and reflect upon the relations between children and the use of medication, particularly of stimulant medication, is under the framework provided by the medicalization thesis. Although under this concept lies a large and heterogeneous field of ideas and theories, most seem to agree that in a broad way, this refers to the process by which conditions of everyday life are turned into biomedical conditions. This therefore makes the use of biomedical language, models, procedures and definitions necessary in order to approach and understand something that previously was conceptualised in a non-medical way.

One of the key figures in studying the medicalization movement, Peter Conrad (2007), points out that in contrast to what people tend to believe, the process of medicalization does not have to be necessarily rendered as something bad, hazardous or problematic. That said, medicalization has been closely linked to other processes which have raised suspicion amongst many critics. Processes such as over-medicalization of human conditions, or potential uses of medicalization as a way of social control have been strongly criticised by social scientists. Stimulant medication is one of the common examples employed to illustrate how medical knowledge and practices may be wielded in an attempt to control children's behaviours, hence shaping their potential future outcomes as productive adults or responsible citizens. Under this perspective, the increasing numbers of children diagnosed with mental health problems and the increasing figures of stimulant medication consumption can be examined as forms of controlling and shaping childhood.

Although the approach provided by the medicalization thesis is indeed insightful and revealing of many underlying determinants of the interaction between children and stimulant medication, I claim that this approach runs into some severe shortcomings when it comes to engaging with the actual everyday lives and experiences of the subjects who are involved in the very same medicalization process. Even more, the medicalization thesis not only lacks engagement with the aforementioned, but also

mostly deprives children of any kind of agency or capacity of reacting to, and making something out of, the processes in which they are involved. Under the consideration of most of the medicalization thesis, children emerge as passive victims of the expansion of medical categories and knowledge, their bodies, actions and behaviours colonised as they lack agency. It is as if instead of being another actor in the different dynamics involved, children were only the field where others dispute, argue, wrestle and enact these dynamics and processes.

It is because of this that my other goals in this chapter are to introduce some key notions provided by two other bodies of work. First, one that can be loosely called 'anthropology of pharmaceuticals', although some work by individuals who do not necessarily locate themselves in that category are also to be considered; and second, to incorporate into the discussion some key insights and contributions of what came to be known as 'New Childhood Studies' or 'New Social Studies of Childhood'.

By introducing the former, I aim to introduce the novelty of considering how the interplay between medication and individuals can be deemed a process of mutual shaping that goes beyond the idea of the colonisation of certain aspects by categories and knowledge emanating from the biomedical realm. I claim, in accordance with some of the available literature, that the interaction of both individuals and medication can be considered as mutually constitutive and therefore worth exploring, instead of purely as an object of suspicion. To do so, this body of work centres its attention on the actual practices conducted by individuals in their relation to medication. As Jenkins (2011) argues, the interaction between individuals and drugs cannot be understood on the basis that individuals just engage passively with medication, excluding the experience of those who take them, along with the consequences this produces in the environment in which the individual is immersed.

By the introduction of Childhood Studies, my intention is to bring into consideration the idea that children are also active agents in the shaping of their everyday lives. Although most accounts from the social sciences tend to consider children as merely vulnerable and stripped of the capacity to act and produce changes, Childhood Studies provides the necessary tools to reconsider this assumption, enriching the potential discussions when it comes to further reflection upon their interactions with other

actors, such as the medication, their peers, and adults. My ultimate goal is to draw attention to the fact that, by considering children as endowed with agency, and stimulant medication as not something to be considered merely as a way of social control, it is possible to re-shape the classic ideas about the potential benefits and hazards of children's use of medication in such a way that will reveal more complex, interesting and rich interactions between both.

An overview of the 'medicalization thesis'

When talking about the 'medicalization thesis', I am referring to a broad and heterogeneous body of research which has gained popularity in critical social sciences since the 1970s. It is important to remark that medicalization refers both to an analytical term and to a social phenomenon. As a phenomenon, historians and anthropologists have placed its beginning in the early eighteenth century, related to the process of modernisation of western societies and to the implementation of public health programmes by the modern states. Since then, the process of medicalization has reflected a modern concern, which has translated in the implementation of 'societal and medical practices designed to control and regulate diseases, illness and injuries' (Bell & Figert, 2015, p. 20). As a concept, its popularisation probably began in 1972 when Irving Zola published what in time became a ground-breaking article, 'Medicine as an Institution of Social Control'. In this article, Zola introduced the word 'medicalization' which became a powerful concept that would help expand the horizons of medical sociology and of other disciplines interested in the social implications of medical breakthroughs (Conrad, 2015). Although medicalization and other related concepts have experienced different formulations by the many individuals interested in the topic, scholars and researchers inspired by this theoretical framework are keen on exploring and responding to the same fundamental concerns: why has the medical institution steadily expanded in modern western societies, and what are the consequences of its growing influence, reflected in how its concepts and ideas have become more widespread, being now frequently used to explain and treat processes which previously were perceived as linked to non-medical causes? (Conrad, 1992; Zola, 1972).

Those inspired by this analytical tool look critically to what they deem an illegitimate involvement of medicine in the management of society. Whether one agrees with their suspicions or not, it seems undeniable nowadays that through the proliferation of medical language and concepts, the ‘institution of medicine’² has increasingly managed to cover, classify and diagnose several different aspects of human life. Similarly — and thanks to their efforts — it is now commonplace to argue that as a consequence of this expansion, medical terms and concepts have become central in how individuals understand themselves, refer to their experiences, and ultimately construct themselves through daily actions and interventions (Bell & Figert, 2012; Lakoff, 2000).

The forces driving the medicalization process have been extensively discussed for decades. Since its beginnings, special attention has been placed on analysing childhood as a significant case study to understand how medicalization works, under the idea — held by early scholars working with this concept — that deviance was one of the principal focus of this process. As the studies conducted by Peter Conrad and Joseph Schneider reveal (1992), deviance exhibited by children went through a gradual process of transformation, from being initially understood as a moral problem to its current medical framing. This reconceptualisation of deviance entailed that now it is being defined, controlled and treated by the medical establishment. Similarly, many other aspects of children and adult lives have been redefined, switching from being considered as social, moral or legal issues, to their current comprehension as medical matters (Bell & Figert, 2015). Children have been considered as particularly prone to be captured by the explanations offered by the medical apparatus, mostly because they are not considered to be ‘resistant individuals’. They are more ‘medically made-up’ than adults (Rose, 2007). In practice, this idea translates into everyday interventions which puts children under constant scrutiny. At home, but especially in schools, children’s actions are constantly examined for signs of anything that might resemble a deviation from social norms. Similarly, their whole process of development has been increasingly understood under biomedical terms. Now, children are

² When referring to the ‘Institution of Medicine’, I also aim to encompass and consider the enormous variety of appendages that emerge from it, from medical diagnosis to pharmaceutical products

constantly measured, compared and evaluated through their lifespan, without having much chance to say or do anything about this.

Because of this alleged vulnerability, scholars have turned their attention to children to understand how medicalization processes operate while mostly criticising the consequences of such endeavour. From the standpoint of critics of the expansion of the medicalization process, the medical apparatus — its language and concepts — is being used as a sophisticated device of control, one that has replaced more traditional and ineffective ways to deal with children's deviance and peculiarities in the past (Burman, 2008; Parker, 1995; Rafalovich, 2013; Timimi, 2002).

But childhood is just one of the many topics that have been analysed as being reframed in medical terms. Historians such as Robert Nye (2003) and sociologists like Joseph Davis argue that similar criticisms were formulated in the 1950s, when writers and scholars started examining 'the growing importance of psychiatric concepts, mental disorders, and psychotherapy in matters of crime, delinquency, and behavioural problems more generally' (Davis, 2006, p. 51). But probably it is only with the works of Irving Zola (1972) and others such as Eliot Freidson (2007) and Ivan Illich (1976) that a clear conception of what 'medicalization' was, and how its logics operate, were possible to articulate. Since then, the 'medicalization thesis' became a conceptual matrix to face what they considered as the sociological problem of the expanding limits of medical knowledge.

However, the 'medicalization thesis' is far from being a unified and articulated theory. Peter Conrad, one of the most well-known scholars working in this body of work, has claimed that although much literature can be found under the label of medicalization, there is no common agreement about how this process takes place in practice: 'Most agree that medicalization pertains to the process and outcomes of human problems entering the jurisdiction of the medical profession, but there are differences in the way they see the process' (Conrad, 1992, p. 210). The discrepancies about how the process takes place have grown stronger over time, and additional doubts have been posed in the very core of the medicalization thesis. This questioning is closely linked to changes in the way biomedicine is now conceptualized, taking into consideration how it has changed in relation to the way it was run and conceptualised in the 1960s and 70s, and

how it has now become entangled with technoscientific and social changes, giving birth to what some have called 'biomedicalization' (Clarke, Mamo, Fosket, Fishman, & Shim, 2010; Clarke, Shim, Mamo, Fosket, & Fishman, 2003). By coining this new name, some have stressed that medicalization is no longer the same, and that it is necessary to notice 'the increasingly complex, multisited, multidirectional processes of medicalization that today are being reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine' (Clarke et al., 2003, p. 162).

These quarrels are far from trivial. They reveal how since the 2000s, science and medicine have endured such dramatic and profound transformations that early explanations and theories of the causes and consequences of medicalization need to be reassessed. It is safe to venture that the classic notion of medicalization is currently in need of auxiliary concepts if it aims at continuing to be a pertinent concept with which to analyse the social world. At least three major concepts have joined the debate: 'pharmaceuticalization', 'geneticization', and 'biomedicalization'. Each one of these concepts has its supporters who feel that their focus and emphasis better allows scholars to explain the current endeavours of medicine and the forces driving their efforts. To some (Bell & Figert, 2015), the emergence of these concepts reveal the simplest, yet crucial question, that this body of work has to answer: is the addition of these new engines best suited for describing and understanding how science and medicine is carried out in the twenty-first century or is it necessary to come up with a new concept altogether? Or in other words: is medicalization — and the profound and constant changes that the concept has undergone with the turn of the 20th century — still a useful concept, or do we need to think about this matter differently?

As a consequence of the multiple understandings of the forces pushing and driving the processes of medicalization, but also motivated by the constant re-elaboration of the concept and its tendency to encompass more and more phenomena, the 'medicalization thesis' has been heavily contested during the last decades. Instead of becoming a richer analytical tool because of its transformations, some have argued that it has turned into a weaker concept, a sociological cliché, or a useless tool for social criticism. In the words of Joseph Davis 'the medicalization thesis has lost its way.

It encompasses too much and it stings too little' (2006, p. 56). Or as Nikolas Rose argues, 'the term medicalisation might be the starting point of an analysis, a sign of the need for an analysis, but it should not be the conclusion of an analysis' (2007, p. 702). This is because as an analytical term, medicalization seems to obscure more things that it helps to reveal. Furthermore, the idea that medicalization has evolved into something new, being now a different process that no longer follows the same directions and logics which initially it pursued, has not been accepted by everyone working under this theoretical framework. Conrad's more recent work has stressed how, even though medicalization has been modified because of social changes that modulate how the whole building of medicine and medical knowledge is performed, it is still possible to address the problem in a similar fashion as before. The important thing, Conrad argues, is not to lose focus on the medicalization process by trying to comprehend too much, or by making the spectrum of analysis too broad: 'I see shifts, where they [Adele Clark and her colleagues] see transformations. I see medicalization as expanding and, to a degree, changing, but not morphing into a qualitatively different phenomena' (Conrad, 2005, p. 5).

The troubled waters of the medicalization thesis have not reached a unified standpoint regarding what their object of research is, and about how they think the medicalization process occurs. Considering this context, the thesis about the medicalization of childhood — which encompasses a wide-ranging area of analysis of how biomedicine has engaged and dealt with the phenomenon of childhood, particularly with the idea of deviance by children — have also shifted across time. Nevertheless, some major trends can be mentioned.

The many shapes of the medicalization of childhood: the use of medication and the menace of social control

As mentioned in the previous section, the 'medicalization thesis' has given considerable attention to how the medical institutions have provided new methods of colonising different aspects of children's lives that were previously under the dominion of different understandings. Historical reviews inspired by this body of work have sought to confirm this hypothesis time and time again, by arguing that the relation

between the medical apparatus — the knowledge it promulgate and the interventions that arise from it — and children has developed, at least since the second half of the last century, mostly guided by the interest of the ‘institution of medicine’ to slowly but surely provide a new explanation about how childhood should unfold, creating navigational charts to follow and measure the progress of such enterprise. This kind of analysis can be traced back to the first explorations on the topic, conducted by Peter Conrad in the 1970s (Conrad, 1992; Conrad & Schneider, 1992). But some argue that similar attempts were conducted even earlier, as is revealed in the works of Maurice Leufer on hyperkinetic disorders in the 1950s and early 60s (Sadler, Jotterand, Lee, & Inrig, 2009).

More important than when the first studies took place is to understand the ethos of such inquiries. The first case-studies of the medicalization of childhood aimed to understand and make explicit the process by which some new diagnostic categories and therapeutic methods emerged during the twentieth century, emphasising how and to what extent this process served the interests of some minority groups to control and deal with deviant behaviour (Conrad, 2006). In that sense, the critics of the medicalization process expressed their concerns about how being different was now being deemed and treated as a medical condition (Conrad, 2007). The sensitivities exhibited in these studies is highly relevant for understanding our current situation. After all, until now most reflections in social sciences and the humanities about the interactions between children and the medical apparatus — especially when it comes to mental health — seems to follow the same cautious and critical attitude towards models, developments and inputs coming from the biomedical sciences.

Broadly, what worried the social critics examining the process of medicalization was the way in which the institution of medicine became a tool for homogenisation of human differences. Early scholars examining the medicalization of childhood claimed that what was once considered as the normal variability between individuals was now being reframed into pathologies. Once they had become understood under such terms, the medical apparatus developed different technologies to deal with them, either by eradicating such behaviours, or at least by providing means to tame what were now considered as disorders or diseases. Models and standards of how children

should act and behave were provided by an expanding medical institution, along with strategies and techniques for social intervention aimed at steering children's lives, as they argued that the 'troubled mind' of the child was in constant need of correction through different methods and in different settings (Rafalovich, 2008). It is important to highlight that most analyses made by those who stand opposed to the medicalization of childhood are more complex — and therefore less naïve — than normally presented by those criticising this body of work, who normally reduce these analyses to simplistic ones.

Undoubtedly, the medicalization thesis has provided important and relevant insights in relation to the mutual determinations between pharmaceutical industries, the development of social policies, and the proliferation of certain diagnostic prevalence and medication consumption rates. Even more, at times they do not even argue against the medicalization of certain aspects of human life, as their critique has evolved to be directed to the over-medicalization of human differences (Conrad, 2007). Nevertheless, until today it has been possible to find a great number of researchers inspired by this theoretical approach who have the persistent idea that, what finally remains behind the expansion of biomedicine — especially mental health — is nothing more than a subtle technique of social control.

It is in a similar vein that some of the key scholars working in this field of inquiry have addressed the issue of children's consumption of medication, and specifically the use of stimulant medication (Conrad & Schneider, 1992; Conrad, 2006, 2007). Overall, they have argued that this kind of treatment presents a sophisticated attempt to regulate and control children's unwanted behaviours and actions by making use of biomedical knowledge to deal with what society considers as deviant in children when it comes to how they live their lives and express their individualities. This kind of treatment — they tend to argue — is presented as a silver bullet, a solution to a vast range of problems which range from school behaviour to social impairment. Scholars inspired by the medicalization thesis argue that pharmaceutical treatments for these conditions must be contested because, ultimately, their use of the medication is not solving real medical conditions, but rather conditions which reflect nothing more than social sanctions for being different in a world where children are expected to fulfil

several criteria of productivity, autonomy and sociality (Breggin, 2001; Malacrida, 2004). Following this rationale, the expansion of biomedical diagnoses — such as attention-deficit/hyperactivity — and treatments — such as the use of stimulant medication — must be evaluated with extreme care and cautiousness, as their expansion reveals how these means of social control become more deeply entrenched in our everyday lives

Once the relationship with the biomedical sciences and the medical apparatus has been defined under these rather narrow assumptions, it is no accident that the self-imposed role of those working under the medicalization thesis is aimed at revealing how different power mechanisms — through biomedical related contents — have infiltrated our everyday lives through different sets of knowledge and practices. In turn, the newly-founded ways of acting and knowing about ourselves have shaped how our identities are built, fostering new kinds of personhoods which are more aligned with the requirements of current disciplinary societies (Donzelot, 1997; Lemke, 2002; Rose, 1985, 1998). Medicalization plays a significant role in how these new identities are framed, which becomes more evident when taking into consideration what Ian Hacking calls ‘the looping effect’ (Hacking, 2000, 2004). According to Hacking, once individuals are classified, they interact with the category, in this case a medical diagnosis, and they are likely to change because of these interactions. He argues that ‘if new modes of description come into being, new possibilities for action come into being in consequence’ (Hacking, 2004, p. 108). Regarding the medicalization thesis, this translates into the following: once the expansion of biomedical categories manages to conquer something previously explained in a different fashion, this would be named, described and understood differently. Once a diagnosis is performed, it will modify the way in which we previously understood a certain phenomenon. By considering Hacking’s argument, it must be stressed that is not only our conception of what is being targeted by the diagnosis that changes, the individuals also change, that is, the ones being targeted, as does also the category used to classify them: ‘They [the ones being classified] are moving targets because our investigations interact with the targets themselves, and change them. And since they are changed, they are not quite the same kind of people as before. The target has moved. That is the looping effect’ (Hacking, 2007, p. 2).

Considering the potentially hazardous consequences of such a looping effect, the medicalization of childhood has faced constant opposition by critical scholars during the last decades. How adults should understand and deal with the difficulties and challenges arising from children's everyday lives has become a battlefield where opposing forces clash and argue. Critical scholars have rejected the increasing use of biomedical models, claiming that reducing the problems and difficulties experienced by children to a biological level is a reductionism that dismisses and/or conceals other powerful determinants that also play a significant role in the categorization and understanding of what we have come to currently consider as 'normal', 'pathological', or 'ill'. However, and despite the stark opposition of scholars inspired by the medicalization thesis, the boundaries between what is normal and what gets to be considered as abnormal has undoubtedly been blurred and later reshaped with the introduction of a 'biomedical gaze' commanded by the expert assessment of the medical apparatus, which has facilitated evaluation criteria and actions plans for children to be 'healthy' and 'normal' since the beginning of the twentieth-century³. To some, current discussions are even moving from a biomedical understanding of life and daily struggles, to a neuromolecular or genetic appraisal of the individual (Abi-Rached & Rose, 2010; Rose & Abi-Rached, 2013; Vidal & Ortega, 2017) — which still, in some views, including my own, have not fully managed to penetrate lay understandings of childhood (Singh & Wessely, 2015). The reshaping of the boundaries between the normal and the pathological thanks to the expanding influence of the medical apparatus has not only entailed a new understanding of how children should be measured and valued, it has also implied a reconfiguration of the rationale being used to consider potential interventions and treatments, and to appraise what is pertinent and efficient when dealing with the troubled minds of children.

ADHD works as a good example of the aforementioned dynamic. For scholars who are critical of the medicalization of children, a careful examination of the diagnosis of ADHD reveals how labelling the child with a biomedical disorder offers a false mantle

³ A more detailed discussion about this matter can be found in Nikolas Rose's 'Governing the Soul', particularly in the third section titled 'the child, the family and the outside world'. Also, see Alan Prout's thorough description of the topic in 'The future of childhood', specifically in Chapter 2, 'Childhood studies and the modern mentality'. Both books are listed in the references.

of scientificity (Conrad, 2006) which needs to be unmasked. They argue that ADHD is not a 'real disorder', but only an attempt to intervene in children's moral flaws by using biomedical knowledge (Rafalovich, 2008, 2013). What they claim is most problematic about this is that once actions and behaviours exhibited by children begin to be framed under this biomedical rationale, other potential aetiologies or causes explaining their actions and behaviours begin losing their credibility and popularity, and they slowly fade away.

Undoubtedly, there is truth in some aspects of the analysis conducted by these scholars. However, as Robert Nye (2003) realises, one of the major problems of early versions of the medicalization thesis in general — but especially when it comes to understanding children — is that too easily their analysis falls into a rigid ideological or conceptual framework, understanding medicalization as 'a nefarious collaboration of experts and state authority imposed from above'. Such ideological understanding of the term has led to 'constant temptation to veer off into unqualified damnation of a "medical Leviathan"' (p. 117), or to arguments that are just too radical and inconsistent with both the experiences revealed by archive and fieldwork. Partially, the radicalism of their accounts can be produced by strong embeddedness in socio-constructionist approaches (Prout, 2011; Tisdall & Punch, 2012), which can lead to several shortcomings (Hacking, 2000). By the same token, the arguments and claims of those working with the thesis of the medicalization of childhood usually do not take into consideration a vast amount of evidence and potential benefits that come along with the medicalization process, as I will discuss in the next section.

Those who stand opposed to the medicalization of childhood have, notwithstanding their shortcomings, and consistent with their interests and efforts, produced some significant insights in relation to the children's consumption of stimulant medication and to the expanding prevalence of mental disorders such as ADHD. These are insights that must be considered, as they reveal how tags and labels coming from the medical apparatus are prone to be affected by social, moral and economic factors. In that sense, I stand aligned with scholars claiming that ADHD — and other biomedical categories — cannot be reduced to a conspiracy between pharmaceutical industries, medical experts and state authorities; but also, its current prevalence rates and the

ways we currently make sense of the diagnosis and its treatments cannot be exclusively pinned to a biomedical rationale (Greene, 2008; Singh, 2008). In analysing how psychostimulant medication comes into play as a first-line treatment for dealing with ADHD, theorists inspired by the medicalization thesis aiming to produce more complex and less ideological examinations have a lot to say.

There is an increase in diagnostic categories including core symptoms related to attention and behaviour problems, with a strong emphasis on ADHD (Harwood, 2005). In Chile, for instance, studies show a sharp rise in the prevalence of ADHD diagnosis from an average of 3% to 7% in 2003 to 10.3% in 2010 (Roizblatt et al., 2003), a figure that remained similar in the latest epidemiological study performed in 2013 (de la Barra, Vicente, Saldivia, & Melipillan, 2013). These figures become more relevant considering the global prevalence rates indicated in the major diagnostic manuals used in mental health⁴. Moreover, studies using meta-analysis place a worldwide population prevalence percentage of 5% of school-aged children (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007). Due to this, ADHD is considered one of the most frequent chronic behaviour problems in childhood (Harwood, 2005).

As denounced by the medicalization thesis, during the last thirty years the main hypotheses and clear majority of biomedical research have attempted to account for ADHD by emphasising the supposedly neurobiological condition, damage or disorder. Accordingly, its diagnosis and treatment is dealt with mainly on the basis of psychotropic drugs and psychostimulants (Buttinghausen G et al., 2011), that is, by taking a neurobiological approach to the subject. The emphasis on a biological substrate for ADHD is contradicted by the lack of objective methods to verify the physical basis for ADHD (Radcliffe & Newnes, 2005). Critical childhood psychologist Nick Radcliffe and children and adolescent psychiatrist Sami Timimi, both well-known experts and critics of the biologisation of ADHD, highlight the need to analyse this diagnosis as a construct that is susceptible to inquiry, by stating the following:

⁴ DSM-IV establishes a prevalence of 3 to 5%, and the CIE-10 of 1.7%.

The cultural dynamics of this label cannot be understood without first understanding the cultural discourses and power hierarchies that exist in contemporary Western society. It is a very compelling and dominating story invented and perpetuated by those whose interests are served by its telling and retelling (ADHD was literally voted into existence in the 1980s by the American Psychiatric Association when drawing up the third edition and third edition-revised versions of the Diagnostic and Statistical Manual). (Radcliffe & Timimi, 2005, p. 64)

The medicalization thesis focuses on how the biological approach to ADHD — and other conditions now considered part of the biomedical realm — may certainly have the potential outcome of ignoring and silencing other questions of great importance. This is of great relevance, especially because these questions may change the way in which we regard not only the causes, but also the treatments, and the way in which we relate and engage with these conditions. One of these questions taps into the social construction of a diagnosis, whose naturalisation in medical nosology seems to lead us to forget its origins and future implications (Singh, 2002).

In summary, the medicalization thesis reveals important questions and concerns when reflecting on childhood, medication, and the way children live their everyday lives. They have brought into light important dynamics and relations between different actors that, indeed, have an impact on how the diagnosis circulates socially, and in what treatments are considered as useful for dealing with symptoms linked to the disorder. They have also pointed out the narrowness of pure biological approaches to ADHD, highlighting the importance of taking into consideration cultural determinants. Nevertheless, these (ideological) analyses tend to be too influenced by socio-constructionist approaches — with the subsequent shortcomings explored during this section — while dismissing relevant evidence that supports the need for different approaches. Being too adamant in depicting the topic of ADHD as the result of an illegitimate medical expansion, the possibilities of observing the benefits and potentialities that medication entails becomes clouded. Therefore, more nuanced analyses are needed to unwrap the role that medicalization and medication play in current societies. These analyses are more aligned with evidence produced during the

last decades, which can flag the real impact medication has in people's lives, as I will discuss in the following section.

Time to move forward: A critical appraisal of the medicalization thesis

As Robert Nye (2003) noted more than ten years ago, the concepts and moral dilemmas which came along with the first studies about medicalization have indeed changed over time. Mainly, the central change that can be found in the specialised literature concerns the emergence of new voices arguing that what was once considered as the illegitimate expansion of medical knowledge is nothing to be afraid of, and that there is nothing 'bad' about this expansion, therefore necessitating that new stances towards the medicalization of certain aspects of everyday life should be raised.

In accordance with this rationale, I will outline some of the critiques that during recent decades have been made of the medicalization thesis. This is relevant, even necessary, to develop new analyses regarding the interaction of individuals, biomedicine and its related technologies. It is by going beyond the medicalization thesis that it is possible to reflect and produce more nuanced approaches in relation to the entanglements between biomedicine and individuals, analyses that might take into consideration some of the potential hazards denounced by those working with the hypothesis of the medicalization of childhood, but also the benefits and advantages that accompany such a relation.

As mentioned, there are some that have opposed the idea that medicalization is something to be avoided or feared. Intentionally addressing the fact that, on the one hand, medicalization has made us what we currently are; and on the other hand, considering that such a process is not something that has to be necessarily deemed harmful or risky for the individuals, Nikolas Rose (2007) openly argues about the necessity of taking into consideration the crucial role biomedicine plays in the current understanding of ourselves. 'Medicalisation has become a cliché of social critical analysis' he claims, as his reading of the situation does not attempt to dismiss the potential benefits of being critical of medicalization, but rather to help realise that

other major factors are being left outside the analysis proposed by the medicalization thesis: 'There is, no doubt, much to criticize. Yet medicalization has had an even more profound effect on our forms of life: it has made us what we are' (p. 700). The idea of going 'beyond medicalisation', as he titled the article in which he reflects upon the subject, is to highlight that medicalization is not much of an explicative matrix, since it does not address how, why or what are the consequences of the extension of medical authority beyond its legitimate boundary, whatever this might be.

Rose's claims about rethinking the potential benefits and the real extent to which medicalization is already an integral part of our current understanding of ourselves requires us, first of all, to stop thinking about medicalization as something abstract, and start analysing 'cases' of medicalization. That is, what becomes necessary is to realize that instead of being a concept to critically analyse an abstraction such as 'the illegitimate expanding influence of biomedical knowledge', medicalization can become a sharp tool to elucidate a process of transformation of human conditions of life, and open a discussion about values, functions and interests. Instead of dismissing something as the result of a process of medicalization, what I argue in accordance with some scholars who have open this field of discussion (Parens, 2013; Rose, 2007; Rose & Novas, 2008; Sadler et al., 2009) is that the fact of something being medicalized, and therefore understood in a biomedical language and under biomedical causes, is the beginning of the process of analysis and not the end of the same. By taking this stance, the field of analysis allows the introduction of new actors into the scene, highly enriching the potential uses and reflections when engaging with the subject, as Sadler and colleagues have argued (2009).

So, I follow the argument that the debate must no longer be a discussion of medicalization or non-medicalization, or between choosing between medicalization or 'the traditional manners to face social and moral problems', whatever they are. By changing the theoretical framework, the debate becomes about good and bad forms of medicalization, as Erik Parens suggest (2013), which can only be decided after examining what is involved in every specific case. This implies carefully measuring all aspects, positive and negative, involved in every particular case or process before actually stating that to medicalize something in one specific context is a good or bad

thing to do. Going back to my case study — the relation between Chilean children and the use of stimulant medication — it is indeed important to acknowledge the relevance that pharmaceuticals industries have played in how the process of medicalization has been conducted — which has been noticed by some in other countries (Bell & Figert, 2012; Mayes, Bagwell, & Erkulwater, 2009), although it has not been thoroughly studied in Chile — as it is also important to observe the importance of public policies in the expansion of the disorder (Rojas Navarro et al., 2017). However, these analyses only point to the movements and interactions at a macro level, telling us little about the consequences that these dynamics entail when they are translated to particular cases of the everyday world. Subsequently, they exhibit similar shortcomings and pitfalls to those found in the classic studies of medicalization previously discussed, but these gaps could be bridged by complementing such studies with others inspired by different approaches, aiming to engage with the divergent and everyday lifeworlds of individuals and their medications.

In addition to the critiques made by Rose (2007) against the overall argument stated by most of the literature available related to the medicalization thesis, I claim that there are two other factors that make it necessary to create distance from this approach for the sake of my research interest. These arise from the distinctive underlying logic to how medicalization theorists examine the process of medicalization. I consider this logic both fruitful and detrimental at the same time. The same strengths of this approach are what I consider to be their major flaws when it comes to examining the actual experiences of engaging with medication. I will summarise these ‘weak spots’ of the medicalization thesis basically in two broad ideas, traceable in most of the writings of academics working under the scope of the medicalization theory. These weak spots of the medicalization thesis can be found in studies about the medicalization of different topics regardless of the subject being examined: ranging from the medicalization of childhood (Conrad & Schneider, 1992) to the medicalization of death (Illich, 1976) or the birth and operationalisation of new medical categories such as diabetes or hypertension (Greene, 2008). In this sense, they are not exclusive to the medicalization of childhood, as the same common rationale is implemented for analysing multiple topics. This rationale normally comprises two different processes which I consider insufficient to deal with my research question.

First, I find their tendency to employ genealogic approaches as something to be overcome. When I mention that proponents of the medicalization thesis use a genealogic method as part of their examination of the problem, I aim to highlight how one of the main aims of this approach is exploring when, how, and whose interests are involved in the transformations in how we understand specific human phenomena. The way they try to unravel and understand the popularisation of biomedical terms, concepts and diagnoses is mostly by using epidemiological data and statistics, by focusing their attention on the figures related to the population, the sales of pharmaceutical industries, and the use of pharmaceutical products. Despite the utility and impact that this approach produced in the current understanding of human beings, this leaves out of the picture how actual individuals experience and give an account of their processes of engaging not only with the medication, but with all kinds of pharmaceutical and biomedical technologies, products and knowledge. Taking that into consideration, I claim that the medicalization thesis proves to be unsatisfactory when it comes to exploring what are the actual interactions between the individuals and medication. In their attempts to denounce the spreading of the biomedical realm to fields of knowledge that remained 'natural', 'untamed' and 'unexplored' until that moment, what scholars working in relation to the medicalization thesis (i.e. Conrad, 2006; Conrad & Schneider, 1992; Illich, 1976; Malacrida, 2004; Rafalovich, 2013; Timimi, 2002) did not acknowledge is that the potential interactions between individuals and the biomedical realm are not only deeper and richer than they cared to explain, but also that many unexplored interactions and possibilities for the individuals lay right at that point where the medication and the individuals meet.

Although this was not considered by those working with the medicalization thesis as a tool for social critique, it was spotted by other who considered what a fruitful chance for research this could be. A rich vein of experiences and possibilities opened up for those who saw the interactions between individuals and medical knowledge as a vast field of possibilities to change, improve and explore new outcomes and new ways of being. Examples of the above mentioned are numerous, from the consideration of how the entanglement of biomedical knowledge and human beings allows the emergence of new forms of life (Rose, 2007; Vidal & Ortega, 2017), new ways of 'biosociality', ethics and values (Gibbon & Novas, 2007; Rabinow, 1996; Rose & Novas, 2008) among

others. Above all, what re-thinking this interaction entails is the chance to reshape our relationship with the biomedical realm in terms of opportunities instead of normalisation, of mobility and chance, instead of social control. As Nikolas Rose (2006a) observes:

Our somatic, corporeal, neurochemical individuality now becomes a field of choice, prudence, and responsibility. It is opened up to experimentation and to contestation. Life is not imagined as an unalterable fixed endowment. Biology is no longer destiny. Vitality is understood as inhering in precise, describable technical relations between molecules capable of “reverse engineering” and in principle of “re-engineering.” Judgments are no longer organized in terms of a clear binary of normality and pathology. (p. 40)

In summary, there is a lot to come after the medicalization thesis. The new approaches I detailed above locate themselves in the exact blind spot that those working on the medicalization thesis cannot or refuse to see: the multiple chances and opportunities that accompany the interactions of individuals with the biomedical realm. However, in a similar fashion to their counterparts, the works by those who seek to go beyond the medicalization critique presents some of the same flaws in relation to the goal of my research: they also get somehow lost in the seductive big picture of the genealogy and epidemiological accounts, while my focus is the actual experiences of those being transformed and transforming their everyday lives through their interactions with the medication. However, as I will discuss below, there are some who have stressed this point in a way similar to mine, focusing attention on what this relation entails in terms of everyday life.

A new question then arises. If we leave the medicalization thesis behind, what else is there? I argue that by walking away from the classic models used by the medicalization thesis it is possible to engage with contributions coming from different frameworks which, I argue, grant the possibility to introduce mainly two important differences with most of the previously mentioned literature about individuals, biomedicine and its corresponding ramifications and fields of actions. The first is the chance to think positively or differently, or at least to withhold judgment about the effects of medicalization to think in relation to cases, instead of what can be deemed an ‘ideological’ or biased manner about the subject. To do so, it is necessary to encounter the actual experiences of the ones involved. The second variation to be found is that

in these new contributions, individuals can be considered as active agents, instead of only being deemed the effect of processes and clashes of forces which are larger than them. I will now analyse the perils and benefits of introducing both these variations, and why I considered the need to introduce them to reflect in an original way on my topic of research.

Between enabling and constraining: the shifting roles of medication in a person's life according to social scientists

In a 2009 article authored by Suzanne Fraser, Kylie Valentine and Celia Roberts, the authors wonder about the current state of our societies, and the multiple relationships that we as individuals establish with pharmaceuticals everyday of our lives. 'Our culture is a scientific and biomedical one, saturated with drugs and drug-taking' is their opening statement. Later on, they continue their reflection lucidly by arguing that 'The hopes attendant on pharmaceuticalisation are sometimes reduced to simplistic, yet powerful, formulation: one day there will be a drug to fix everything. So too the anxieties: we are surrendering the richness of life to medical classifications, and consuming drugs rather than experiencing culture' (Fraser, Valentine, & Roberts, 2009, p. 128). They continue their argument by saying that anxieties like these assume a clear separation between the medical and the social, and between culture and science, and that the true call these days is for social scientists to problematise, analyse and finally overcome these distinctions to understand how, nowadays, we live with and through drugs. These are not things that stand in opposition, but rather elements that commonly, in daily lives, work in unison.

I find their argument thought-provoking. But apparently, I am not the only one, as lately social scientists have opened themselves to reflect about the role played by medications in different contexts and situations, searching for explanations far beyond the explanatory matrix given by the notion of medicalization. As observed by some, it is hardly possible to think about and reduce the role of pharmaceutical intervention merely to what can be considered as marketing efforts, or a planned medicalization programme that generates artificial disease categories, transforming in the process every individual into a multiple-drug consumer (Greene, 2008). To think the opposite,

to ascribe the use of any medication by individuals to tactics conducted by those trying to advance the medicalization programmes, is a paranoid polemic rooted in the idea of an omnipotent medical profession in constant expansion over healthy individuals who do not even need that expansion, and as Green claims, the process of interaction between medication and individuals is much more complex than that.

One interesting way to approach the interactions established between pharmaceuticals and individuals can be found in the ethnographic accounts made by the field of what has come to be known as 'anthropology of pharmaceuticals' in general, and the work of Emily Martin (2006, 2009) and a few others in particular (Geest, Whyte, & Hardon, 1996; Gomart, 2002, 2004; Jenkins, 2011). For those working on this sub-discipline of medical anthropology, pharmaceuticals are to be considered as a central feature of biomedical technology, which acquire greater importance since, as Van der Geest and his colleagues (Geest et al., 1996) mention:

(...) As powerful technical devices and cultural symbols, medicines acquire a status and force in society. As medical technology, pharmaceuticals are not only products of human culture, but producers of it (...). They move people into establishing, avoiding and breaking off social relationships. To say in Lévi-Strauss's well-known words that medicines are "good to think" (and act) with, renders them insufficient justice. Their role in human life extends much farther, for they use people as much as people use them. (p. 156-157)

What strikes me as particularly relevant in how these researchers conceptualise the emergence of pharmaceutical drugs in everyday life is that, for them, medication ceases to be considered as an unwanted consequence, one of the many aftermaths of an expanding biomedical apparatus. On the contrary, pharmaceuticals are important active agents which can engage with an also active individual in a variety of forms which range from a gentle coming together to relationships marked by processes of mutual struggle and accommodation. Their role extends far beyond those classically described by traditional theories. They get to be 'portals', as Jeremy Green calls them, which allows us to peer in and observe distinctly social history: 'they form "collective sampling devices", through which we can observe the social tectonics underlying contemporary policies of health and normality' (Greene, 2008, p. 5). This conceptualisation of how pharmaceuticals come onto the scene not only opens more

options for these interactions between the medication and individuals, but also connects these dynamics with a wider spectrum of actions. Pharmaceutical drugs are then to be considered as crucial agents in social transformations, representing the intersection of different interest parties.

Furthermore, this approach opens the possibility of thinking about benefits and innovation instead of only perils and normalisation when it comes to the interaction between individuals and pharmaceutical drugs. Medication can be considered as conferring actions and capacities that were not present in the individual before they started consumption. This way, actions can now be considered to be 'shared', built between the two of them, while, for their part, entities simultaneously can be considered to influence and be influenced, as they can be restrictive, constraining and liberating at the same time. As Gomart (2002, 2004) calls them, these 'generous constraints' are forces that 'induce and give a chance' to behave differently:

When constraints become inductions rather than obstacles to action, autonomy ceases to be the pre-condition for activity. Such new forms of influence or performativity are impossible to fit into the neat dualism of autonomy/subjugation supposed by the liberal definition of freedom. These, however, become imaginable, as constraints become generous. Humans and things (including drugs?) can now engage in mutually constructive relations. (Gomart, 2002, p. 552)

Medication and individuals can interact and, even more, they can produce something new which is neither of the above. Medication is not only to be considered as a form of social control or normalisation, there is more to it than that: the possibility of a 'pharmaceutical person' emerging, a new matrix of analysis that shifts the discussion away from the medicalization thesis (Martin, 2006, 2009). What appears to be a messy blurriness of different actors is actually a coordinated dynamic of coming together of things usually considered to be part of different ontological orders. Thompson call this an 'ontological choreography' (Cussins, 1996; Thompson, 2005), a dynamic coordination of several different orders, such as of the technical, scientific, kinship, gender, emotional, legal, political and financial aspects. In other words, an ontological choreography implies the mixing together between relations established in certain and precise contexts, bringing together a heterogeneity of things to produce something

specific. Medications aim to target a specific understanding of what human beings are, and modify through their specific actions how we understand and relate with our emotions, wishes, actions, among others. Considering that we are, indeed, somatic individuals embodied within a certain biological constitution, 'neurochemical selves' as Rose (2003, 2006a) puts it, it is understandable how the role of pharmaceutical medication has become stronger, as its ability to influence our lives develops under the same rationale.

Emily Martin has argued that when, in practice, researchers have addressed the everyday actions and relationships that people establish with their medications, what comes to light is that the process is more nuanced than commonly suspected. In line with the reflections of Emilie Gomart, Martin argues that our understanding of how medications work should not be reduced to the image of an external force which, as consequence of its frequent use, ends up shaping the individual from the outside. The actions of pharmaceuticals are richer, and extend beyond replacing a previous personhood with another, chemically imposed upon the individual by the medication. Pills, she argues, are regarded by users with a certain 'ambivalence'. They are not considered as something intrinsically bad, used to coerce the individual. Rather, users tend to coat pharmaceuticals — and their relation with them — with two different and interacting sets of values, one negative, but also one positive (Martin, 2006). This seems to be related with the fact that the effects of the medication, and the possible interactions that it can establish with the consumer, cannot be reduced to simplistic explanations since these dynamics are affected by multiple variables, such as the rationale behind its deployment in people's lives. In relation to this, sociologist Andrew Lakoff (2005) have noticed in relation to pharmaceuticals that

they are the means to various possible ends. Tracing differences in their use and meaning provides a window into broader differences in regimes of health and forms of governance. As we will see, the achievement of 'specificity' requires the adoption of a set of concepts and techniques that reconfigure both the object of expert knowledge and the self-conception of the expert. (p. 10)

If we follow the claims of social scientists researching the multi-layered topic of pharmaceuticals from a standpoint more closely connected with the actual experiences of those using the medication, it becomes possible to grasp how the medication and the related practices to its uses and consumption enable the possibility for a 'pharmaceutical self' and a 'pharmaceutical imagination' to emerge, the former being bound to the 'subjective experience of psychopharmaceuticals' such as the psychostimulants, and the latter to 'the global shaping of consumption' (Jenkins, 2011). Both of these are under constant reshaping, as the knitting between the individual and the medication gets constantly reframed in the process. They are the product of fragile assemblages — as I explore in the final chapters of this thesis — with their boundaries blurry at times, and mobile at others. But, overall, they are in constant reshaping and accommodation.

Pharmaceuticals enable people to see, understand and deal with themselves and with others differently. However, and regardless of the rich vein of research that could explore these dynamics, there is no specificity about how these processes occur when the ones consuming the medication are children, as there is little to no research about the topic. Most of the literature about children and pharmaceutical drugs remains under the domain of the medicalization thesis, and few attempts to move past that framework have been conducted. This may have to do with some underlying notions about what children are, their capacities which are still deemed weak, and their place in the social order which is still subordinated to adulthood.

Next, I will explain why rethinking the role of medication is not enough but it is also necessary to reflect differently about how children's capacities and abilities unfold. I argue that this must be re-examined to further understand what the actual interactions between medication and children are, and how this interweaving amongst the two also involves other actors in specific settings, such as the school, in particular 'ontological choreographies'. To do so, I will introduce some key concepts that enables us to think about children as social actors, active agents in shaping their lives, and later I will address some of the specific cases in which children as active agents have been involved in research about stimulant medication.

What about children? Stimulant medication, children's experiences and the question of agency: new perspectives

How is it that, contrary to adults, children have been mostly overlooked when it comes to thinking about them actively doing something, engaging and displaying some real involvement in terms of their relation to biomedicine, in general, and with (psychostimulant) medication in particular? I claim that this largely responds to the underlying consideration in most research conducted in social sciences that children are essentially different from adults when it comes to considering their status as valid research subjects that can engage with the researchers, have opinions and points of view of their own. This consideration of children — as objects for research, but rarely as subject co-constructing or actively participating in the research — is deeply rooted in principles established at the beginning of the twentieth century by evolutionary and developmental psychology, and is currently being disputed by researchers working in critical psychology and childhood studies (Burman, 2007, 2008; James & Prout, 1997).

During most of the Modern era, childhood and children have frequently been considered in a particular way, which lately has been criticised. As it has been observed for many researchers studying children, most of the approaches to them start with the assumption that children are an incomplete version of a human being, an individual still developing, in process of becoming something, instead of being considered as already 'being' a subject (Uprichard, 2008). So, while adults are thought about as a coherent unity, children are deemed a heterogeneity of different features and attributes which are still finding their way into consistency, into coherence, to later become 'something': childhood as the opposite of adulthood.

The establishment of childhood as the reverse of what adults are has been an assumption deeply rooted in social sciences during the last century, and before that as well (Christensen & James, 2008). As Alan Prout (2005) depicts it, childhood has been associated with specific values and notions. Thus, it had become almost automatic to link childhood to categories such as 'private', 'natural', 'irrational', 'dependent', 'passive', 'incompetent' while 'play' is considered as their main activity, while, on the other hand, adulthood is portrayed as the opposite: being an adult gets related to

values such as 'public', 'culture', 'rational', 'independent', 'active', 'competent', with 'work' its main occupation.

Only a few researchers and theorists have attempted to think and act differently towards childhood, by reflecting upon children as social actors endowed with the capacity to engage with social life, claiming that they can participate in research settings not only in a passive way, but rather being active social actors since children have lives and experiences worthy of being explored on its own terms. The leading role in this new framing of childhood is to be granted to what was named as 'New Social Studies of Childhood'. This framework aims to think of children as dynamic social agents, who participate in an active way in the construction and experience of childhood. According to Hendrick (2008), children are capable not only of social action, but also of establishing meaningful and enriching relationships with other people and with the world.

'New Social Studies of Childhood' is a vast and rich field of theoretical and methodological debate, which has helped re-shape some of the basic underlying notions for those interested in childhood and children's lives. I do not intend to do a full review of the rich and multiple debates and crossroads that can be found under this theoretical framework. For the sake of my research, I introduce only a few central conceptions coming from this body of work, which I claim are necessary to think about the subject of my research without repeating the shortcomings of the medicalization thesis. For instance, I find it crucial to acknowledge that children's everyday lives are something to be explored in alliance with children, endorsing their opinions and experiences. This entails trying to avoid assuming what their everyday lives are like, since any conceptualisation of what is important, what is not, and how important and trivial things fit together that is made by the researchers would indeed be conceptualized from an adult-centred perspective that cannot be avoided. I agree with Jenks (2005), when arguing that children's social relationships and cultures are indeed worthy of study in their own right, despite the perspectives and concerns of the adult world. Consequently, children should be encouraged to speak about their experiences with medication as they experience it, thus trying to overcome what they are told to feel, experience or be, according to the adults. Children's subjectivities are not

epiphenomena of medication, neither they are obliterated by its use, as most of the medicalization thesis seems to consider. Children act back, engage and interact with the medication. They can make use of the medication to become recalcitrant (Savransky, 2014), which locates the question about the effects of the medication and about children's capacities to act together, or to act back, away from lay assumptions thinking that children can only be normalised via the use of psychostimulants.

The above makes it necessary to rethink the notion of agency as it has traditionally been conceptualised when it comes to children. While medicalization and social control theory mostly deprives children of agency by thinking about them and their everyday lives as the result of other processes and dynamics, such as for example, the economic interest of pharmaceutical companies (Conrad, 2006), the shift proposed by those trying to endorse children with renewed agency thinks differently about the subject. Children's agency has been a central concern for these scholars (Christensen, 2004; A. James, 2007; Pinter & Zandian, 2014). Through different approaches and methods, New Childhood Studies have attempted to highlight their agency, particularly by emphasising that children should be listened to, since they are key informants when it comes to understanding children's everyday lives (Christensen & James, 2008). Instead of thinking about children as passive and dependent, this body of work claims that children are competent and active agents.

The renewed notion of agency and accountability that comes along with thinking that children are active agents in the shaping of their worlds and experiences must be measured and taken into consideration when reflecting about the relations they establish with adults and with the medication. Additionally, it is necessary to consider the social, cultural, historical and material circumstances in which these relations occur (Dockett & Perry, 2007; A. James & James, 2012; A. L. James, 2010; A. James & Prout, 1997; Prout, 2005). Agency, under this scope, is contextual of the milieu, but at the same time constitutes and shapes the same.

Introducing the notion that children can be deemed agentic individuals allows to reframe our reflections in relation to the interactions between children, stimulant mediation, and their social and material context. Although most analyses of the topic tend to put their analytical emphasis on determinants other than the role the child

plays in such dynamics — for instance, the links between stimulant medication's consumption and the diagnosis of ADHD (Hawthorne, 2010), the way in which other actors gather and interact around and because of the medicated child (Frigerio, Montali, & Fine, 2013), or the potential hazards and relations linked to the use of the stimulant medication (Charach, Skyba, Cook, & Antle, 2006) — a few have included children in their analysis, stressing their role as active actors and highlighting their reports while being medicated. These researchers — whom I feel more in tune with, because of their ethical and methodological concerns when approaching the topic — frequently try to highlight how the experiences, perceptions and actions reported by the child can be considered as important assets in order to make decisions regarding medication, diagnosis, treatment and policy making (Brady, 2014; Bray, Kirk, & Callery, 2013; Cohen & Morley, 2009; Hawthorne, 2010; Mills, 2014; Parens & Johnston, 2009; Singh, 2007a; Singh et al., 2010; Singh, 2012). Most of them seem to share the belief that it is necessary to include children not only as the receptors of processes being performed upon them, but also as active agents that can — within certain conditions and limitations — have an active role and opinion about the dynamics in which they are immersed.

The conclusions obtained by these different researches are far from being homogeneous. At times, they are even contradictory on their most fundamental and basic findings, such as how children feel towards stimulant medication (Mills, 2014; Singh et al., 2010; Singh, 2012). But this heterogeneity should not be an impediment, but rather a call to keep researching these matters. Instead of quickly dismissing different results as 'wrong' or 'false', it seems more productive and cautious to think that these results still need more variables to be unveiled so we can understand the different potential outcomes. So far, it feels like a step forward that researchers have started engaging with actual children, instead of only jumping to conclusions from archive work, genealogical approaches or adult-centred discourses.

In summary, there are only a few who have engaged with children's interactions with stimulant medication, and although their findings are still scarce and sometimes contradictory, this opens the door to continue reflecting upon how it is that these apparent contradictions can be explained by looking at the subject not in terms of how

one variable affects another — the role of medication in children’s everyday lives — but rather in terms of how everything comes together and acts upon each other. To do so, I claim that it is necessary to focus not only on children’s verbal reports of what is happening and how they feel about the use of medication, but via a different path: by exploring the practices held in a specific setting, such as the classrooms, and taking into consideration how exploring practices enables new understanding about how the different actors interact and relay among each other, giving birth to specific ontological choreographies where particular things come into being.

My focus on studying practices in the classrooms is underpinned by two things. First, in the understanding that experiences related to the use of the medication are not performed alike in all settings, as the sociomaterial context plays a significant role in how these experiences are shaped, and certain individualities can come into existence. The creation of subjectivities and processes of agencement emerging from the interactions between children and stimulant medication are, to a significant extent, dependent of the context, as they are not to be considered as inherent properties of human nature. Agencement understood as ways of producing sense and agency that exceeds the previous state of affairs in which the interacting objects were, as there is a modification of the previous distribution of these capacities. These can only be understood by considering that individuals are in a constant state of becoming via interactions with others with whom they interact when certain events bring them together (Phillips, 2006). Considering this, agency and subjectivities are not to be exclusively found ‘inside’ the body of children. Rather, they imply ‘practices, agencements, folds, fusion of heterogeneous terms in composition (but also in conflict, with noise, and many times in friction with each other), through socio-technical *dispostifs*, discourses, practices of government, of the self and of others, without which our experience of subjectivity could be other, or even inexistent’ (Arruda-Leal, 2011, p. 360). Aligned with this, I claim that any social phenomenon must be studied within a given context, since that context plays a powerful role in shaping how that phenomenon is going to be performed. So, when it comes to studying the effects and entanglements between children and stimulant medication, the classroom seems a privileged context to conduct such research. This is because children are commonly diagnosed and start medication because of how they engage with activities in that

particular setting (Hawthorne, 2010; Mayes et al., 2009; Timimi & Taylor, 2004). Similarly, the effects of the medication are expected to be displayed in the setting of the classroom, in terms of social behaviour, school work and other school-related functioning (Singh et al., 2010).

The second reason why I am engaging with practices is because previous approaches to this subject have mostly omitted the practicalities that underlie the encounter between children and medication. By practices I mean recognisable and regular arrays of activities which are carried on by agents in more or less successful ways through time and space. Practices are loose configurations of routines and rituals that are susceptible to change according to different contexts, but that tend to be sustained and acted by knowledgeable actors (Punch & McIntosh, 2014). Considering my interest in the unfolding of effects produced in the relation of children and stimulant medication, I intend to study practices since they reveal a certain knowledge located primarily in activities, procedures, events, and so on (Mol, 2002). It is a knowledge *performed* in the classroom under the specific conditions previously mentioned. It is by exploring what is being performed, that I claim new understanding can come into being, understanding that may highlight how human beings and other human and non-human actors entangle together, not only through the description of actions and behaviours, but also stressing how practices configure socio-technical arrangements that not only organise conducts, but also make up certain individualities (Du Gay, 2008). Additionally, analysing practices allows us to take a different stance on what happens in the classrooms. It entails considering that events and actions taking place in such a setting are not only the effect of behaviours, agencies, or attribution of meaning which are exclusively mobilised thanks to an 'inner essence' of individuals, but rather the results of fragile and ever-moving arrangements that need to be followed and that, in such a process of unwrapping how agencies are distributed, each individual — even a child — can act as 'ethnographers of their own lives' (Mol, 2002, p 15), in the sense that they can give an account of the events in which they take part — discursively, or with their action.

Conclusions

The theoretical trail that I have displayed until this point was aimed mainly at accomplishing two things. The first, to make the reader acquainted to the traditional bodies of work that engage with the topic of children and pharmaceuticals, while making clear the reasons why these bodies of work present significant shortcomings and deficiencies that render them unsuitable to, by themselves, address the research questions I aim to explore. Secondly, to present the foundations where my own work will locate itself, illuminating the main relations that my own approach to the topic has with the previously mentioned bodies of work. Undoubtedly, the theoretical frameworks mentioned — the medicalization thesis, the anthropology of pharmaceuticals and, finally, New Social Studies of Childhood — have recognisable and well-known strengths. However, it is my claim that it is only by piecing together bits and pieces originating in all that some new reflections and standpoints can emerge. After all, it is only by making new questions, and opening to the possibility to be surprised by the fieldwork experience, that new reflections can come to light.

As argued, I first intend to move away from what is probably the most traditional and common way in which social sciences have reflected upon the interactions between medication and childhood: the medicalization thesis. My argument for doing so is that most of the research conducted by these scholars is adamant in their antagonism towards the medical apparatus, not considering the potential benefits that appear when thinking differently about the interactions between individual and biomedical products and knowledge. However, I still intend to keep some of the inspiration that shapes this body of work: the consideration that when it comes to biomedical categories, treatments and artefacts, there is more involved than ‘pure biomedical facts’. But, contrary to what most of this literature implies about the dangers and perils of biomedicine’s expanding influence over the social worlds, I align myself with those who see in this expansion a field of opportunities, of potential benefits, and future developments which are more likely to be beneficial, but that are still in need to be explored and researched (Gibbon & Novas, 2007; Lock & Nguyen, 2010; Rabinow, 1996; Rose, 2003, 2007; Rose & Novas, 2008).

To think about the potential benefits of the aforementioned, and considering that my interest lies in the use of stimulant medication, I turned to the field of expertise that

probably has most strongly addressed this matter, in such a way that the complexities and multiple angles and facets involved in the process have been highlighted. The sub-field of medical anthropology called ‘anthropology of pharmaceuticals’ has reflected upon this topic, highlighting that medication is to be considered as much more than just something people ‘just do’, or as a process of external shaping performed by the medication upon a docile body. I intended to show how, through their ethnographic work, these scholars have explored the multiple and rich interactions between medication and individuals, and how via these interactions new subjectivities can come into being (Gomart, 2002, 2004; Martin, 2006, 2009). However, experts working in this field of expertise have not engaged—with a few notable exceptions (Prout, 1999; Bush et al., 1996)—with the particularities that come along when the ones interacting with the medication are children, which presents further difficulties since children have been historically considered by social sciences and the social adult world as deprived of agency or capacity of action, being normally located as an epiphenomena of adult actions (James & Prout, 1997; Uprichard, 2008).

It is because of the abovementioned that I turned to the ‘new social studies of childhood’. This body of knowledge has researched childhood and children’s lives, but contrary to other approaches, they have stressed the notion of agency, endorsing the capacity of children as social actors, considering them as being able to act and produce modifications not only on themselves but also in their surroundings (Christensen & James, 2008; Lee, 2001; Mayall, 2002; Prout, 2005). So, if both stimulant medication and children are reflected as gifted with agency, it is now necessary to explore how both engage with each other, and how the particular settings and the other actors also come into play, enabling or constraining the potential of agency. This is because, as David Oswell (2012) lucidly notices when criticising the classic approach held by the new sociology of childhood,

Children’s agency is, of course, important, but in the context of the assemblage of elements and with respect to a particular politics of engagement, the question of what is to be done cannot be reduced to the politics of either/or, active or passive (...) Agency is always relational and never a property; it is always in-between and interstitial; and the capacity to do and to make a difference is necessarily dispersed across an arrangement. (p. 270-271)

It is because of what is mentioned above that I decided to explore how these interactions take place by looking into the practices taking place inside the classrooms, as a way to observe and examine how these relations and interactions take place, while being open to the idea that the multiple actors present in the classroom, both human and non-human (the stimulant medication) have the capacity to produce modifications. In this, I followed not only the idea displayed by Oswell about agency as relational, interstitial and dependant on certain arrangements, but also some of the ideas of Alan Prout (2005) and Affrica Taylor (2013). They also take a critical standpoint to some of the foundational assumptions held by the 'new social studies of childhood', such as the reduction of childhood to a social and historical construction, an idea deeply rooted in a socio-constructionist framework. To this, Prout replies that 'childhood and child-related phenomena are formed of assemblages of heterogeneous materials' (p. 141) which range from technological, to social and biological. He claims that, in order to understand the merging together of these heterogeneous materials, it is

important to move away from the idea of a determinant process in which one entity, biological, social or technological drives this process. While the properties of nature and culture are not infinitely malleable, they are over-determined, in the sense that they are complex, emergent and open to contingency. In fact, the entities that we call "biological", "technological" and "social" are already networked together. (p. 141)

Bearing in mind that child-related phenomena, and children themselves, can be considered as composed of multiple elements such as the social, the biological and the technological, all interacting in multi-directional processes, and that agency is to be found equally distributed amongst these elements — human, non-human —, in order to fulfil the purpose of my research, I decided to explore these interactions in one particular context, the classroom, and focusing mainly in practices which involve both children and the stimulant medication. The reason why I chose to focus on stimulant medication and how it interacts with children is because I claim — and this aligns with arguments held by anthropologists of pharmaceuticals previously described — that medication helps to blur the classic delimitations between the biological, the social, the natural and the artificial. Stimulant medication destabilises these boundaries which are normally taken for granted and, as Prout (2005) mentions, focusing on this

kind of problematics 'provides instances of the assemblages of culture and nature, of society and technology, and of discourse and materiality to which those studying childhood must give their attention if we are even to begin to understand the trajectories that childhood will take' (p. 141), while focusing on the classroom responds to the fact that this particular setting has been studied to be directly related to children's starting consumption of stimulant medication because of how they are perceived to act and behave by others, such as the teachers and the staff members of the school (Hawthorne, 2010; Mayes et al., 2009; Prout, 2005; Timimi & Taylor, 2004).

This research aims to explore all of the aforementioned by focusing on studying the practices inside the classroom. As has already been stated by some (Gad & Jensen, 2014; Schatzki, Knorr-Cetina, & Savigny, 2001), 'practices' is something hard to define since 'practice' has multiple connotations. They are referred to in different manners by different authors, sometimes being used as an analytical starting point, while others consider them as an empirical focus for social enquiry (Gad & Jensen, 2014). As mentioned before, I will explore practices because I consider that that is the best way to explore and reflect upon the interactions held inside the classroom. This requires the consideration of practices in a specific way. In accordance with Andrew Pickering (2001), the study of practice suggests that a social theory of the visible is enough, it being unnecessary to invoke hidden structures, in the way that structuralism or other theories normally do. In this sense, Pickering stress that 'a theory of practice, then, would focus our attention on specificity, on particular interdefinitions of machinic and social fields' (p. 173). This aligns with my interest in studying interrelations and mutual determinacies as they are performed in the classroom. Following what Annemarie Mol (2002) suggests, I aim to explore how realities come into being through a wide array of practices, which are, as Gad & Jensen (2014) suggest, 'comprised by multiple forms of agents' (p. 701). For Gad & Jensen (2014) 'Mol's empirical philosophy extended the empirical and conceptual rubrics of practice studies. In this work, ontology spoke to the mutual shaping of people and things that cross, or rewire, 'the local' and 'the global' as much as the 'empirical' and the 'conceptual'. The emphasis on ontological transformation pointed to changes in the very composition of the world, accomplished through all kinds of means, including some that might at first glance seem quite un- or impractical' (p. 173).

Chapter 2

Understanding the methods behind this research: tools for a different approach to a critical topic

Nature and context of this research

Children as agents, and the reason for engaging with practices

Aims and objectives of this research

Study design/methodology, data collection and how to analyse the collected data

Selecting the research participants: sampling and selection criteria

Recruiting the participants: schools, parents and children

Ethical considerations and ethical issues

About data protection

Conclusions

In this chapter, I aim to introduce the reader to the reflections and choices I made in assembling a methodological approach which could offer the possibility of engaging with children's use of stimulant medication differently from the way in which it is normally studied. As I decide to move away from traditional approaches, arguing that they are unable to rescue and understand fully the located experiences of children using stimulant medication in particular settings, it becomes important to assemble a methodological framework coherent with such aims. Since this is mostly an unexplored area, every decision had to be carefully considered, as developing this methodological approach also entailed putting together aspects of different bodies of work that reflect differently on how fieldwork should be conducted, or on what kind of data is relevant for building arguments.

Having established my interest in how stimulant medication and children cohabit and interact inside the classroom, and after revealing the key pitfalls and concerns I have regarding the ways in which this topic has been studied and theorised in the past by

others, my choice is to conduct my research using a different approach to those mentioned in the previous chapter. I focus on an ethnographic approach to the subject of my interest, which I justify in the need to explore the practices performed inside classrooms, practices performed by the medicated children in relation to other human and non-human actors, and practices concerning and related to medicated children but performed primarily by others, such as teachers and classmates. Exploring practices permits the achievement of two things which have been largely overlooked by most researchers. First, it enables us to engage with the practicalities found in the everyday lives of those composing and playing a role in the execution of the practices performed inside the classroom; and second, exploring practices allows us to go beyond — although it also opens space for — reports about experience given by these potential actors. As Mol (2002) claims, the study of practices helps to reveal a particular knowledge which is barely accessible if the researcher does not engage with the activities, procedures, events and other practicalities happening in the selected setting.

However, the study of practices has not been an analytical focus for scholars exploring how children interact with stimulant medication. Therefore, this literature does not provide a methodological path to follow in order to conduct such explorations, as their approaches tend to portray children as lacking a sense of agency, being mostly considered as the effect of the result of processes of socialisation being implemented on them by other actors. For its part — and although they exhibit a clear interest in rescuing children's agency — most research conducted under the inspiration of Childhood Studies seem happy to acknowledge that children can exhibit agency, but mostly they do not explore the circumstances under which agency can be expressed, nor how their agency is reliant on other actors (Bordonaro & Payne, 2012). Additionally, researchers inspired by Science and Technology Studies — a field which has been prominent in thinking about the importance of practices and the intermingled origins of the process of agencements — have shown little interest in researching children. However, it is worth mentioning that during the last decade some researchers have tried to bridge these gaps. It is now possible to find a small group of researchers sprouting out of the field of Childhood Studies who, just like me, have developed an interest in studying the intermingled properties of childhood, drawing

inspiration from other fields of expertise, especially Science and Technology Studies, relational materialism and post-humanist theories (Kraftl, 2013; Lee & Brown, 1994; Lee & Motzkau, 2011; Murris, 2016; Prout, 2000, 2005; Ryan, 2012; Taylor, 2013; Taylor & Blaise, 2014). I believe my research is aligned with their sensitivities and interests. Sadly, when I first started crafting this project, their contributions were still mostly scattered, being only recently unified in a more coherent fashion. Therefore, at the moment I was starting this research, I could not lean on them to provide a unified and coherent methodological or theoretical framework which I could use as inspiration. Hopefully, this thesis will now be a contribution to this emerging and exciting field of inquiry.

Considering the difficulties arising from exploring the topic in the way I position my research questions, in the proceeding sections I review the key methodological issues that I took to overcome the aforementioned pitfalls. In what follows, I present the reader with key elements of the problematisation, as I attempt to provide methodological answers about how to better engage and respond to these core elements. In other words, I present the arguments that led to the construction of this research, what I proposed to tackle them, what I actually did, how I did it, and what this method enabled me to do. Finally, I conclude this chapter by outlining some of the shortcomings to bear in mind about my own approach.

Nature and context of this research

During the past 5 years, Chilean society has witnessed a significant increase in the use of stimulant medication, particularly in the capital city of Santiago. This increase took place concomitant to a rise in the resources allocated by the Government to purchase stimulant medication. During 2011 to 2012, resources to acquire methylphenidate were doubled by the Chilean government, so the demands of the public health sector could be satisfied, according to data provided by the *Central de Abastecimiento del Sistema Nacional de Servicios de Salud* (Supply Centre of the National Health Services) or CENEBAST. Additionally, and in concordance with the figures supplied by CENEBAST, the International Narcotic Control Board (INCB) placed Chile in the top ten countries in the world for consumption of methylphenidate on 2013 (International Narcotic

Control Board, 2013), which reflects the high demand of this type of medication in the national context.

The abovementioned is both intriguing and a matter of concern. Intriguing, considering that lately there has been a stark opposition to the consumption of stimulant medication by some lay groups, which has been echoed by mass media through the publication of articles in several newspapers and online news portals. Interestingly, these efforts do not seem to match or correlate with the steadily increasing figures provided by the official bodies, both national and international, which reveals how stimulant consumption keeps increasing. This has become a matter of concern because, even though the Chilean government has tried to tackle the excessive use of stimulant medication, their initiatives appear to have been mostly futile.

How medication affects the medicated children has been debated both at an international level and at the local Chilean context, being contested by both experts and lay people (Advokat & Scheithauer, 2013; Becerra, 2013a, 2013b; Breggin, 2001; Conrad, 2006; Mayes et al., 2009; Singh, 2007b; Singh et al., 2010; Singh, 2012; Timimi & Taylor, 2004; Wilens et al., 2008). However, despite some negative critiques over the use of methylphenidate and other stimulants in children (Breggin, 2001; Conrad, 2006; Timimi & Taylor, 2004), the consumption of this type of medication has increased in several countries around the globe, including Chile (International Narcotic Control Board, 2013).

Stimulants such as methylphenidate have been identified as the most common way to treat the symptoms of Attention-deficit/Hyperactivity Disorder (Brady, 2014; Mayes et al., 2009; Mills, 2014). Even though methylphenidate is considered a 'safe drug', untoward side effects have been reported. These range from loss of appetite and sleeping problems, to others more severe and rare, such as the development of psychiatric symptoms or cardiovascular problems (National Institutes of Mental Health [NIMH], 2012). In addition to clinical concern related to side effects, clinicians, scholars and researchers have also raised questions about the ethical implications linked to the use of stimulants by children. This has led to a call from experts and researchers interested in childhood to produce empirical evidence to explore the effects of the medication not only on a symptomatic level, but also as it relates to ethical concerns

such as how the medication may compromise children's 'authenticity' and moral 'self-understanding' (Singh, 2007b), or restrict their capacity for moral behaviour (Singh, 2012).

Children as agents, and the reason for engaging with practices

In particular, researchers interested in children's lives and experiences claim that there still is an under-engagement with 'lived realities of ADHD symptoms and drug treatment' (Brady, 2014. p. 219), meaning that children's accounts have not been really taken into consideration by most researchers working in health and social sciences⁵. The under-engagement with children's lived realities is something to be critical of, especially considering that children's discourses on how the medication works provide a useful alternative way of interpreting the effects of the medication, not only in terms of their experiences (Brady, 2014; Singh et al., 2010; Singh, 2011), but also in terms of their ecological niche and other agents involved in children's lives (Singh, 2005). Following a similar sensitivity, I planned to engage with the subject with the hope of contributing to other studies that have already made this a matter of concern (Bendelow, Carpenter, Vautier, & Williams, 2012; Brady, 2014; Singh, 2005, 2013a). To do so, I actively emphasised the need to involve children as active agents (P. M. Christensen & James, 2008; Hunleth, 2011; A. James, Jenks, & Prout, 1998), capable of participating in health-related research, despite being labelled with psychiatric or mental diagnoses (Singh, 2007a). This means that, in contrast to the approaches from those working on the medicalization thesis, or in the anthropology of pharmaceuticals, I considered children as active agents who are capable of inducing change, as does the stimulant medication. This entails a specific way to approach children, which can enable them in an active role, with their qualities and characteristics considered as equally important as to those displayed by adults in normal research studies.

⁵ There are exceptions to this. A small number of researchers working on ADHD and/or the effects of stimulant medication have tried to emphasise children's narratives, fostering the exploration of children's own understandings of their behaviour, symptoms, self, among others. See Brady, 2014; Singh, 2010.

To engage with the subject, I focused on the classrooms since children are commonly diagnosed, and start medication because of how they engage with activities in that particular setting (Hawthorne, 2010; Mayes et al., 2009; Timimi & Taylor, 2004). Similarly, the effects of the medication are expected to be displayed in the setting of the classroom, in terms of social behaviour, school work and other school-related functioning (Singh et al., 2010). I aimed at studying practices performed inside the classroom by the different actors which interact with medicated children, and who are involved with them in their everyday lives. As suggested before, I decided to take a different approach to the subject not only by choosing to give a central role to children, but also because I decided to study practices, as previous approaches to this subject have mostly omitted the practicalities that underlie the encounter between children and medication. By practices I mean recognisable and regular arrays of activities which are carried on by agents — with different success — through time and space. Practices are loose configurations of routines and rituals that are susceptible to change according to different contexts, but that tend to be sustained and acted by knowledgeable actors (Punch & McIntosh, 2014). Given my interest in the unfolding of effects produced in the relation of children and stimulant medication, I chose to study practices since they reveal a certain knowledge located primarily in activities, procedures, events, and so on (Mol, 2002). It is a knowledge *performed* in the classroom under the specific conditions previously mentioned, that is, produced within a range of actions by several different actors. Stimulant medication plays a significant role in this process, as it constrains the child, yet at the same time fosters and allows the emergence of new dynamics and interactions between the different elements and actors involved (Brady, 2014; Singh, 2007b, 2011).

Even though I placed attention on children's narratives, the idea behind researching practices is to go beyond the children's own verbal interpretations of their relation to the medication. What I intended to do is not merely focus on the children's perspective. After all, as Mol (2002) mentions, by following the path of possible meanings, the physical reality of the body is removed from the picture, being replaced by interpretations. In a similar spirit to Mol, I am interested in 'foregrounding practicalities, materialities, events' (p. 11-12) that enable us to see how the relation between stimulants and children that use them foster and enable new developments

as they are put into action and bonded together by practices. The idea was to produce what Clifford Geertz (2010) calls a 'thick description', by going beyond a merely factual description, adding to these multiple elements in order to understand and describe where these facts come from, and what they respond to.

Aims and research questions for this study

Considering the aforementioned description of the current situation of children's increasing use of pharmaceutical stimulants in Chile, the concerns of different parties in relation to this, and the shortcomings of classical approaches to understand the consequences that, in practice, arise from the interactions of children and medication according to children's own experiences, my aims for this research can be considered as two-fold:

My first aim was to advance understanding of the effects of stimulants on how children understand and present themselves through their everyday practices in the classroom. To do so, I analysed the classroom as a specific setting where children display particular activities of their everyday lives. As Scott (2009) points out, in order to explore everyday lives it is necessary to study the places 'where people do (perform, reproduce, and occasionally challenge) social life, day to day' (p.1). My second aim was to explore how the daily practices in which children are immersed in the school's classroom become influenced by the fact that children are taking stimulant medication. By this, I mean to stress how the medication can be considered as a possibility to induce change, to act in a different way and induce novelty (Gomart, 2002, 2004), not only to the medicated child but also to the other actors in that particular setting.

From what I have stated so far, I managed to construct four research questions that guided my fieldwork, and to some extent helped me in selecting the data I present in this thesis. These questions were not to be answered by data provided from conducting a literature review of the topic, but rather through the fieldwork

experience which was conducted from March to September, 2015⁶. The questions that guide this research are the following:

- Can an ethnographic research on practices related to medication provide new information about how medicated children behave and act in the classroom, beyond the data obtained by verbal reports?
- How do stimulant medications mediate children's interactions and relationships inside the classroom according to the accounts of actors present in such setting?
- What practices are performed in the classroom to engage with the medication and the medicated children?
- How is stimulant medication linked to the emergence of new activities and understandings about the actions performed by the medicated children?

Answering these questions required me to piece together an original design. In the next sections, I reveal and detail the methodology and study design that I used, and the relevance and rationale behind choosing this approach over other potential approaches.

Study design/methodology, data collection and how to analyse the collected data

To engage with the abovementioned questions, I designed a step by step plan which started with approaching the schools where fieldwork was conducted, and talking to the gatekeepers to gain access to the schools. My choice of schools, Mount Sinai and

⁶ I state that my fieldwork started in March, since it is in that month that the academic year begins in Chile. However, during the summer holidays preceding the beginning of the academic year — especially during December 2014 and January 2015 — meetings were held with different members of the schools in order to secure access, explain my project, discuss how it could help the schools, the length of my research, among other things. During this process, access was granted, but also important information about the schools was gathered. The opportunity to talk to some staff members and teachers during the holidays proved to be useful, as it was one of the few moments in which they were not overloaded with their work, so they could speak more freely about the schools' culture and ethos without worrying about being late or about the children around them.

Bethlehem, was not casual. Choosing them was guided by three major concerns. First, what has been referred to as 'pragmatic considerations' (Hammersley & Atkinson, 2007) which are expressed in the great amount of legal and procedural barriers that are to be faced when trying to gain access to schools in Chile, with the researcher considered — with all fairness — as an 'external agent' to the academic community, and therefore commonly positioned in the role of someone who is there to judge and report their flaws and shortcomings. Schools are mostly reluctant to let anyone external in. That is why a precious asset was that I already knew two teachers working in the school. This was of great help in navigating through the procedural barriers, securing access, and also helped during the first weeks where my main goal was to be tolerated — and later trusted — inside the schools by teachers and staff members alike. I had known one of the teachers for a long time, since she is related to a friend of mine since my time in high-school. The other teacher was introduced to me by the first one during a dinner party. When they found out about my research project — in its initial stages — they felt that such a project could be of great benefit in general for schools, and were happy to push for my research to be conducted where they were working. Their offer to help me gain access to schools Mount Sinai and Bethlehem matched my interest in studying schools attended by the high-income households — which relates to my second concern.

In general, social sciences' accounts about the use of psychostimulants in Chile portrays them as devices for social control, which might be handed over too easily in public health centres. These accounts describe an ecological niche where the use of medication is being at times pushed by teachers acting out of a sense of helplessness when dealing with overcrowded classrooms in precarious circumstances (Ceardi et al., 2016). For other critical theorists, teachers play a significant role in the spread of ADHD, as they act as 'sickness and treatment brokers' for ADHD by disseminating understandings of the disorder, and suggesting the need for treatment (Phillips, 2006). But, after talking with some teachers working in high-income schools in Chile, I came to realise that the circumstances under which the medication finds its way to the classrooms were not the same. In schools such as Mount Sinai and Bethlehem the number of students hardly exceeds 30 per classroom (while in low-income schools it can reach 50). In a similar vein, while teachers are one of the worst paid professional

careers in Chile, those working in the public sector are additionally exposed to extremely difficult working conditions (Valenzuela, Sevilla, & de los Rios, 2010), which are dramatically different to those encountered in schools such as Mount Sinai and Bethlehem, where teachers can rely on having better infrastructure and material conditions, in having constant training to acquire updated pedagogical skills, and in working with other professionals inside and outside the schools.

In public schools, the sum of harsh conditions configured a popular lay theory: because teachers face enormous difficulties in their work environment, they become more prone to think and use the medication as a quick fix to regulate children's actions and behaviours. But, since in Mount Sinai and Bethlehem teachers are better paid than in popular sectors, they work with a better infrastructure and with fewer children, I hoped that stimulant medication would be symbolically coated with more neutral characteristics. During my time in these schools, I got to observe how teachers leaned on the fact that families could and would search for external help when children were experiencing school difficulties. Contrary to what is reported in more vulnerable schools, where teachers nudge families to take their children with behavioural disorders to the public health centre — which is free and, in some cases, the only external aid children get — teachers in schools Mount Sinai and Bethlehem were confident that children experiencing any kind of academic or behavioural difficulties would be aided in multiple ways. Stimulant medication was not offered as a first line treatment, or as the only choice for these children. Rather, it was normally the last option families would turn to in order to tackle what was happening with their child. Before medication, families would attempt what they consider to be 'less invasive options', as a teacher mentioned to me while sharing her own experience as a mother of a teenager diagnosed with ADHD. Less invasive options can range from private tutors, hiring personal teachers, psychotherapy, homeopathy and other non-traditional medicines, etc. In that sense, the use of stimulant medication occurs amidst a wider range of practices aimed at enabling the child to conduct him or herself and ease their troubled inhabiting of the world.

The third thing pushing my interest in conducting fieldwork in schools Mount Sinai and Bethlehem was linked to my interest in studying children who are normally invisible

for social sciences. As has been discussed for a long time, economic, political and social elites tend to share a 'cultural invisibility' (Gusterson, 1997), granted by their capacities to remain cloaked, making it difficult to research their practices and social trajectories. Being the case that the opportunity to study these schools presented to me by chance, I decided to pursue it, emboldened by the idea that democratic social sciences should attempt to reverse this invisibility by understanding and exposing the practices that grant the elites the faculties to retain their privileges.

Once the schools were chosen, my first step was to approach the schools and talk to the gatekeepers to gain official access to them. After being contacted by the teachers I previously mentioned, the directive board of the schools agreed to meet me and, after an interview held in January, they granted me official access to the schools. During that interview, it was also agreed that my role in the classroom was to be defined by every teacher. Performing a role in the place where the fieldwork is taking place is a customary practice while conducting ethnographic research, since it also grants a better understanding of the context and interactions held amongst the individuals interacting in the field. While some teachers asked nothing of me except that I do my best not to disrupt the normal flow of the class, others integrated me in the pedagogical activities. For example, one English teacher at times asked me to speak in English with her, so the students could hear the dialogues and learn. Other teachers integrated me in different ways. A Maths teacher constantly made me take the same tests and activities as the students, which entailed that I had to sit with them. This turned out to be quite useful for understand children's views about the dynamics and times that the class followed, and learning how they managed to do several different activities — unrelated to the academic contents — without teachers noticing.

After meeting with the management board, I met and explained to the teachers teaching the classes I attended — 'quinto año básico'⁷ — what an ethnographic process is and what was the purpose of my research. In addition, it was explained to them that they were free to refuse to participate in the research, in which case no

⁷ 'Quinto año básico' is part of primary school, normally attended by children aged 9 and 10. It is considered a particularly interesting year to study children, mostly because recent research have revealed that is the hardest level in terms of academic demands for children in Chile (Rosenmann, 2010)

mention of them would be made in my field notes, and all data about them would not be considered for any purpose of my research. I mentioned that that their names were going to be fully anonymised. All teachers agreed to participate, for which they had to sign a consent letter. It was also explained to them that in case they changed their mind about participating in the research they could drop out at any time, and their data would be deleted from my field notes, not being considered for my research. Finally, it was explained to them that they could ask to see my notes at any given time during the fieldwork process.

A similar process was conducted with children — medicated and non-medicated — who were contacted via the schools. Every class has a responsible teacher, who is the one in charge not only of teaching some subjects, but who is also responsible for meeting children's parents, welcoming children in the morning, and conducting other similar activities. These teachers were in charge of distributing a 2-page informative document where the research was explained to children. In the document, it was stated that I was planning to spend some time in their classrooms for the upcoming months, particularly because I was interested in the dynamics and practices taking place every day in such a setting.

The children were also told that they could choose not to participate, and if they did participate, their names were to be fully anonymised and they could choose a different name. In a similar fashion as with the teachers, they were told that it was fine for them to change their minds about being involved in the research at any time. To participate, they had to bring a letter of consent signed by them, and a letter of consent signed by their parents or guardians. No children could participate without having both letters previously signed. The research project was also explained to the parents via a letter written by the researcher, which was also reviewed with the Head of Department of the 'Unidad Técnico Pedagógica' or 'Technical-Pedagogical Unit'⁸, the professional staff in charge of planning, creating, selecting, and modifying the academic programmes, syllabus and pedagogical strategies, among other things.

Since it was not possible to remove the students who were not willing to participate in the research from the observation process, as they share the same classroom and any

⁸ From this point on I refer to 'Unidad Técnico Pedagógica' as 'UTP'

attempt to remove them would only disrupt the normal context in which the practices I intended to explore take place, but also because the schools would not allow this to happen, I proposed an alternative approach to solve this difficulty. After discussing with the 'chief of inclusion' of the UTP, we agreed that all data produced by the students who did not want to be involved in the research would not be considered, meaning that it would not be registered or recorded in any way. This entailed potentially dismissing the data about the part they played in the interactions held inside the classroom, and, under the same premise, they not being interviewed or asked about anything that happens inside the classroom. Luckily, this did not happen. All students agreed to participate, and their parents also agreed.

After getting access and consent, I started conducting fieldwork. This consisted in assisting three days a week, for approximately 8 hours each day, to observe and interact in the dynamics happening inside the classroom. During the fieldwork, I kept a diary where field notes were taken. In addition to this, informal talks and interviews with the individuals involved were held. Also, semi-structured interviews were conducted with children and adults working in the schools. Both the informal chats and the interviews were recorded when the people being interviewed allowed me to do so.

Observations during fieldwork were typed and transformed into notes. In accordance with the ethnographic method, while taking notes a special code was given to whenever an observation was related to the practices involving children and medication in the classroom. In addition, other interactions were also coded in specific ways, for example, for interactions involving medicated children and teachers.

In the next chapters of this thesis, the reader will find different vignettes and excerpts obtained during my fieldwork. Given that it is impossible to include all data gathered during the long period I spent in the schools, I have carefully chosen to share the data that allows for producing a novel understanding of the interactions between children, stimulant medication, and other actors. The purpose for this lies precisely in the fact that there is a vast field of literature addressing how stimulant medication can and will -according to some accounts described in Chapter 1- collapse children's sense of authenticity or selfness. I find that the originality of my approach is to be found

precisely in the opposite direction, this is, in posing a question to could allow to show something different in such interactions. After analysing the data, I realised that I had enough evidence to make such a claim. This is the reason why I decided to make precisely that data the core of this project. However, in trying to avoid giving the wrong impression that medication is always beneficial, I also decided to include some examples and vignettes of what I call 'detrimental entanglements' in Chapter 5. This aimed at providing a more nuanced panoramic view of how children and medication become intertwined together. I intentionally decided to leave out of this thesis the data of cases of children whose interactions with the medication fitted neither a 'virtuous' nor a 'detrimental' pharmaceutical entanglement, as it did not add much to the construction of the analytical matrix I aim to provide in the following chapters. However, these cases, with their peculiarities, still need to be provided with a theoretical matrix that could allow us to understand the reasons why they presented an outcome that did not fit either of the categories I crafted, and that were able to provide an explanation for most cases observed. A potential explanation for these cases might be linked to a different tolerance to the medication, meaning that the dose used by these children might not have been enough in order to produce the chemical reactions needed inside their bodies. However, this is only a hypothesis, and further explorations are in order before I can advance a theoretical explanation for these special cases, supporting why I decided to focus on the cases that I previously described.

The production of the data required for special attentiveness. Since presumably everyone has attended school, special care was given to produce a way of engaging with the context that could enable the researcher to allow himself to be amazed and surprised by the interactions and events happening there (Gordon, Holland, & Lahelma, 2007). As Delamont (1990) mentions, everyone involved in educational research has attended or worked in a school, turning that scene into something familiar, therefore making it necessary to make a constant effort to be aware of that, and do something about it, to turn it into something unfamiliar, hence interesting to be studied and analysed. The principal benefit of researching practices in a school setting has a direct relation to the kind of data that this allows us to gather. In relation to this, Alvarez (2011) mentions that

the object of ethnographies in an educational or school setting is centred on its capacity for allowing us to discover what happens there on a daily basis, by obtaining important data in the most descriptive possible way, for later on proceeding to a process of interpretation and, therefore, enabling a better understanding and possibilities of intervention that better suit the ecological context that classrooms are.⁹ (p. 278)

In addition to the aforementioned, I also gathered and analysed documents and artefacts related to the classroom and to the school in which the classrooms are located. This is usually considered to be an auxiliary technique to observations held by the researcher, and consists mostly in the gathering of documents in different formats (paper, video and audio, either produced by the members of the community being studied or by others in relation to the community), which offer a wide array of information that is necessary to incorporate (Alvarez, 2008). This also helps to situate what happens inside the classroom in a more extended context, which is crucial in order to produce an ethnographic approach that can actually portray, interpret and understand in a proper manner the practices and culture of the ones being researched (LeCompte & Goetz, 1984; Serra, 2004). This became of great relevance, as these documents played a significant role in how ways to proceed were socialised by the schools' members, as I extensively discuss in Chapter 4.

As mentioned, informal talks were held not only with medicated children, but also with their classmates. The point behind the idea of making these conversations 'informal' is precisely to try to avoid turning them into something disruptive, that removes the children from the context in which they perform their everyday lives and practices (Fielding, 2006). By keeping them informal, these conversations were intended not to raise any suspicion or defensive mechanisms from the other students present in the classroom. The idea behind the informal interviews was that they could be conducted simultaneously to everyday dynamics and activities, as they were taking place in the same location, hopefully minimising as much as possible the delay between the activities that might be considered interesting to talk about, and the actual conversations. Therefore, they took place in the same classroom and in the schoolyards. Although there is evidence in literature cautioning that when conducted

⁹ Original in Spanish, translation my own

this way, the conversation can be interrupted by other children around the child who is being interviewed, I found this to be also interesting data to look at, rather than considering it as something that renders the interview null. For its part, semi-structured interviews with children took place in the children's library, where they facilitated a room where no other children could interrupt or overhear the conversation. Teachers and other staff members were interviewed in their offices.

Field notes and the information kept in the diary were later transcribed into more formal notes every day after attending the classes. As mentioned, all the information was fully anonymised according to what the participants previously had chosen. The data produced was examined and used to shed light upon the research questions and the research aims, therefore becoming an essential component for my PhD thesis. To do so, the observations and interviews were codified in accordance to the themes which I have already mentioned. The data collected was only used for academic purposes, being only revealed in academic situations.

Selecting the research participants: sampling and selection criteria

For this research, and in accordance with the goals proposed, it was necessary for multiple participants to take part in the research. This is justified under the rationale that the practices I am interested in exploring are related to medicated children and stimulant medication, but such interactions take place in classrooms where other agents play a role as well. Therefore, three different kind of participants were enrolled, each type having its own justification for participating, which I will detail below.

The first kind of participants involved were medicated children. Initially, I expected to encounter around three to four medicated children per class, as the national average of diagnoses like ADHD — which entails treatment with psychostimulants — is currently around 10% according to some studies conducted in Chile (De la Barra, 2013), and the average classroom has around 35 to 40 students in high-income schools. Additionally, the information provided by the 'Central de Abastecimiento del Sistema Nacional de Servicios de Salud'¹⁰ (Central for Provisioning of the National System of

¹⁰ From this point on I refer to the 'Central de Abastecimiento del Sistema Nacional de Servicios de Salud' as 'CENABAST'

Health Services) or CENABAST showed that more than 60% of the total population diagnosed with ADHD lives in Santiago, increasing the likelihood of finding a higher figure of children using stimulant medication in schools in this city over other locations in Chile¹¹. When I first visited the schools, I realised that although the classes were composed by fewer children than anticipated (no more than 35 per class), the rate of children using stimulant medication matched my expectations. Out of approximately 120 students that participated in the study, 11 of them were diagnosed with ADHD and under pharmaceutical treatment. It is important to remark that even though I asked staff members to tell me the total number of medicated children that they were aware of, one thing I realised is that not all staff members or teachers knew exactly who was medicated. In general, the teacher in charge of the class was the one who had the most information about the topic, but this was not necessarily shared with other teachers. Some reasons driving this conduct were that parents did not want other teachers to know, or other children to know. At times, as interviews revealed, not even the teacher in charge knew about the pharmaceutical treatments of some children. The information was parcelled, and communication about the topic was unclear and not precisely fluent. Partially motivated by this, and in part also attempting to open myself to be surprised by what I could encounter in the classrooms, I asked for the total number of medicated children, but I insisted on not being told about the names of the medicated children, so my observations about the practices would not be tainted. They were told to me only after a couple of months, when I asked for this to be revealed.

The medicated children were aged between 9 and 10 years old. The age limits are related to the age children are when attending the 'quinto año básico'. Normally, children reach this class at 9 years old, and they turn 10 during the year. I also expected one or two children to be aged 11 due to re-taking this class because of academic failure — commonly linked to ADHD diagnosis. However, this was not the case. The reason why I choose to work with children this age is three-fold. First, because there is a lack of knowledge concerning children and their everyday lives. In Chile, there has been a call for experts working with children to further focus on children's narratives and understandings and to highlight the particularities of their experiences from their

¹¹ Figures and data obtained via Chilean Transparency Law

own point of view, instead of only reconstructing childhood from the adult's standpoint. Hence, my interest in exploring the practices performed in the classroom in which medicated children are involved. Second, because 'quinto año básico' is considered a transitional year in Chilean education. It is children's first year in which they now have a different teacher for every subject, instead of a 'head teacher' who oversees most subjects. This change also usually entails an increase in difficulty which causes some students to start experiencing a decrease in their academic performance. In addition, when reaching 'quinto año básico' children start sharing facilities with older children, which also entails new social challenges. Usually both the social and the academic aspects are the ones that underpin the consultations by families and the school about potential psychopathologies in children, and what drives the use of medication. Finally, specialised literature suggests that children should not be diagnosed with disorders or diseases that entail the use of psychostimulant medication, such as ADHD, before turning 7 years old (American Psychiatry Association, 2000). This suggestion — even though in practice it is not always taken into consideration by all mental health practitioners — can be found in the DSM-IV which is still the most used consultation manual for mental health experts in Chile. Additionally, even though the idea that researching with young children is not possible because of their 'immaturity' has been criticised (Gallacher & Gallagher, 2008), it is still more frequent to conduct research with children aged around 9 years old, since they can give a more conscious, clear depiction of themselves, their feeling and ideas about their own lives and what is happening around them (Hunleth, 2011; Pinter & Zandian, 2014).

The second kind of participants were the schools' staff and teachers. The number of teachers and staff members of the schools participating in the research was open to discussion. I was interested in talking and interviewing as many teachers as possible. Finally, I had informal chats with over 20 teachers and staff members and held semi-structured interviews with 10 of them. It is relevant to mention that since both schools belong to the same educational system, it is customary for them to teach both in both schools, hence having the experience of dealing with boys and girls, with and/or without medication. My interest in teachers and staff members was guided by the fact both teachers and professional staff — such as school psychologists and counsellors —

also have an important say in how the schools' orientate the diagnostic process, sometimes suggesting to families for the need of their children to be externally evaluated by a medical professional (Peña Ochoa, Rojas Navarro, & Rojas Navarro, 2015). School staff and teachers were expected to be aged 22 or older, since they could not exercise those roles unless they had obtained a professional degree, meaning no one was expected to be younger than 22 years old. As for the upper age limit, they were expected to be under 65, as that is the retirement age for professionals in Chile.

Finally, the third kind of participants involved were non-medicated children who were also present in the classrooms, constantly interacting with the medicated children. In a similar fashion to what was stated about teachers, the medicated children also interact in their everyday lives, therefore engaging in practices, with their peers. Classmates exercise different roles in the everyday experiences of the medicated children, becoming in this way significant actors whose actions need to be considered in order to understand how practices inside the classrooms unfold. The sample size was defined by the normal number of children currently attending, on average, a Chilean classroom. Considering there were 4 classes, the sample was estimated to be around 120 children. Non-medicated children were expected to be of equal age to medicated ones since they should be classmates. This means that since they also were expected to be attending the 'quinto año básico', these students would likely be aged 9, and they would turn 10 during the year.

Recruiting the participants: schools, parents and children

The selection criteria followed the main research objectives. To ensure that the selected samples of individuals were adequate to fulfil the research's aims, inclusion and exclusion criteria were predefined. By inclusion criteria, I understood the predefined characteristics used to identify subjects to be included in the research. Numerous positive attributes have been listed related to the use of inclusion criteria, such as helping to optimise the validity (internal and external) of the study, improve its feasibility, and minimise ethical concerns (Velasco, 2010). Regarding the exclusion criteria, this refers to predefined definitions that, if fulfilled by the subjects, will render

them unsuitable to participate in the research. Both inclusion and exclusion criteria compose the selection criteria.

The selection criteria for this research followed the subsequent characteristics:

For medicated children:

Inclusion criteria:	Exclusion criteria:
Be at the time consuming some type of psychostimulant medication (methylphenidate, amphetamines, or others).	Is older than 11 years old, or younger than 9.
Be at the time attending the 'quinto año básico' in the selected schools	Is not consuming psychostimulants medication by the time the research was conducted.
Both he/she and his/her parent signed the consent letter handed to children and their parents/guardians once the first contact is made.	Cannot communicate, express or give an account of his/her everyday experiences in the school.
Be aged between 9 and 11 years old	Either he/she or their parents does not sign the consent form.

As mentioned earlier, the age limits were related to the age children are when expected to attend the 'quinto año básico'. Normally, children reach this class at 9 years old, and they turn 10 during the year. However, since sometimes the use of medication is related to poor school performance in academic matters, I expected some of the children could have failed this or any of the previous classes. If that was the case, they would have been one year older, hence the upper age limit of 11.

Researching the 'quintos basicos' seemed a logical choice, since studies conducted in the Chilean education system have shown that this is one of the most challenging stages in the schooling process, which is highly determined by the changes in the pedagogical strategies that somehow efface the familial atmosphere created by having a teacher responsible for teaching children several subjects. Children must deal with increasing difficulties in the academic system, which are redoubled by the fact that now they have to share facilities and some activities with children older than them, which carries new social challenges. Both the social and academic aspects are the ones often underpinning the consultations by families with medical experts, searching for signs of psychopathological behaviour, and driving the use of medication. The search for signs of ADHD and other related disorders — commonly linked to the academic environment — increase from 'quinto básico' as younger children tend to be remain undiagnosed and away from stimulant medication following recommendations of medical experts who advise not to start children on psychostimulants medication before 6 years old, according to the Diagnostic and Statistical Manual of mental disorders (Shaw, Brady, & Davey, n.d.; DSM-V).

For this research, some variables that are often used as inclusion or exclusion criteria for social science research, such as gender and socio-economic background, would not be included. This is because socio-economic background in these schools is mostly homogeneous, as I discuss and analyse extensively in Chapter 4. In relation to gender, it is in fact a very interesting thing to explore. However, focusing on gender requires a whole further study to do it properly. The analysis of gender and its influences on the diagnosis of ADHD and the use of stimulant medication has been discussed in social and biological sciences. In this thesis, I give examples from my fieldwork both from boys and girls. But further analysis should be given to gender as an analytical matrix, which I hope to do in projects to come.

Medicated children's classmates

Inclusion criteria	Exclusion criteria
Be aged between 9 and 11 at the moment	Being older than 11 years old, or younger than 9 at the moment
Be at the moment attending the 'quinto año básico'	Either he/she or their parents do not sign the consent form
Both he/she and his/her parents have signed the consent letter that would be handed over to them once the first contact is made	Cannot communicate, express or give an account of his/her everyday experiences in the school

School's staff and members

Inclusion criteria	Exclusion criteria
Be, by the time the research was conducted, teaching or monitoring the medicated children who attend 'quinto año básico'	Not having a regular interaction with the medicated children

Be aware of who the
medicated children are

Not having signed the
consent form.

Have signed the consent
form

Participants were identified via the schools. As it is commonly known, schools keep information provided by teachers, parents, and external experts about their students. If a student presents a medical or psychological condition, a detailed record is kept, stating the name of the external expert treating the child, and the kind of treatment being implemented. For example, if a child is displaying poor academic performance, the school psychologist or counsellor might ask for the family to check with a mental health specialist, and then get back to them with an action plan, or a list of measures that have been decided to tackle the problem (medication, psychotherapy, academic strategies, etc.).

The use of psychostimulant medication by children, as shown by the specialised literature, tends to be closely related to a child's capacity to perform well in school related activities (marks, following orders, being able to demonstrate the expected behaviour in and out the classroom, etc.). Therefore, along with the medication, schools normally use certain policies once the children start treatment, which in Chile is called 'differential evaluation'. Being under 'differential evaluation' entails that the child may have more time to do tests, with sometimes even a different test being assigned. Also, that when being graded, they may use a different — normally lower — scale to assign the final grade, among other activities that are altered because of the 'differential evaluation' system.

It is because of the aforementioned that the student record was a key element to identifying the medicated children who might participate. The other key element on which I relied to make sure that medicated children were present in the classes I was meant to attend were the reports by teachers. They told me if any children were currently being medicated in their classrooms. But, as mentioned, it was only after a couple of months that I asked exactly who. For the first part of the research, I only

needed to know if medicated children were present. I trusted teachers' reports about the matter, as teachers are the ones that must communicate, or pass the information from parents to the ones in charge of keeping the school records, therefore, they are key agents in the exchange of sensitive information related to children in the schools. The initial approach to contact children was made by the schools. They announced that this research was going to be conducted in the 'quintos básicos'. Once this was done, I personally addressed the topic of the research in the selected classes, where I explained to the students in a simple and clear language what my role was going to be during the upcoming months, and how I was there to explore their everyday struggles, what they considered to be important, their social relationships, how they behave and interact, among other things. Also, it was clearly stated that everything they told me was going to be anonymised, and that they could choose to not be a part of my research or, if they participated, that they could still choose to abandon the research at any point if they changed their mind. Also, a letter of consent explaining the research to the parents was handed over both to students and their parents.

Once the teachers confirmed that there were medicated children in the classes they were teaching, the rest of the individuals participating in the research were selected by taking into consideration who shared and was involved in the everyday practices performed in the classroom that relate to the medicated children. This meant that it was only after making sure that there were medicated children in the four classes of schools Mount Sinai and Bethlehem that the invitation to participate in the research was extended to them, and to the rest of the classes. After all, the medicated children were the key participants for the purpose of this research. By the rest of the class I refer both to the other classmates who interact with them on a daily basis, and to the teachers and staff members of the schools that take part in the everyday practices that involve children who are using psychostimulant medication.

Extra measures were implemented to avoid exposing the medicated children, and accidentally revealing their identities in case they had not been identified yet by their peers. For example, the invitation to participate in the research was extended to all children in the classroom, and all children received the same invitation. Interviews and casual conversation were held with medicated and non-medicated children alike, and I tried to randomise my encounters with medicated children as much as possible —

specially in the first months — to avoid further highlighting the children who were using medication, although I realised while doing fieldwork that their classmates already knew who amongst them were using stimulant medication, and they did not seem to care about it.

Ethical considerations and ethical issues

To ensure that the participants were freely consenting to participation in the research, some measures were implemented. First, the information sheet given to each one of the potential participants clearly stated that participating in the research was voluntary, with no consequences or repercussions of any kind to any individual in case they decided not to be involved in the study. Also, an oral briefing took place at every class involved in the research. In that briefing I made clear that participation was voluntary. This oral briefing was particularly important, since it was a key moment aimed at addressing the information regarding the project with the students, in a simple and clear language, suitable for children their age, who were the key participants of the research. For student that missed the oral briefing for any reason, the possibility was given to ask for details of the research from the researcher at any point during my time in the school setting. Additionally, the consent form also clearly stated that participation was not mandatory, and that they could refuse to take part in the research.

The information sheet and consent form given to students was different to the one given to adults. The ones aimed for children used a simpler language, and tried to avoid any jargon or vocabulary that might be hard for children that age to understand. Both the information sheet and the consent form were handed over to students, their parents and the staff members, who had one week to sign it or to refuse to participate in the project. Those who did not answer by the end of the week were considered as non-participant unless they express their intention to participate in written form. If they did so, any data they produced was only considered from the moment they decided to join the research and brought written consent. Participants that initially had agreed to take part into the research and later decided that they no longer wanted to be involved, were free to ask the researcher to remove them and all the data directly

related to them out of the research. In those cases, all the data gathered related to that particular individual was to be excluded, not being considered for any reports or analysis conducted by the researcher. In that sense, participants had the right to withdraw from the research at any point during the fieldwork, and they also were entitled to ask the researcher to remove their data until one month after the researcher had left the fieldwork. The one month limit is related to the fact that the researcher waited that long for any of the participants to change their minds about being included, and after one month I began writing some chapters in which the data would be analysed. Once the data analysis starts, it was no longer possible to change it without compromising the analysis and results, which would render it necessary to start all over again.

Participants were informed of their right to ask to withdraw, and the time limits for this right, in the information sheet, the consent form and at the oral briefing which took place at the beginning of the research. To make use of this right to withdraw, participants only needed to let the researcher know about their desire to no longer participate in the research. This could be done verbally or through an email addressed to the researcher, asking for this. No explanations were to be asked if someone decided to retire, since this may have restricted their freedom to ask for this right. Luckily, no participants decided to withdraw or changed their mind about being involved after I left the field.

In summary, the ethical issues related to this research project were dealt with in different ways. First, confidentiality was maintained via anonymisation of the data produced during the fieldwork. Additionally, all participants signed a consent form to be involved, which in case of children required both them and their parents/carers/guardians to sign. Also, the participants were not exposed to any stressful context or situation, since the research only aims at exploring their everyday lives, which meant that only their quotidian experiences were the ones being explored, not making it necessary to produce or set any kind of experimental situation to collect the required data.

The research was designed following methodologies particularly tailored for children to feel comfortable with, which entailed that the research was built to be flexible enough to adapt to the circumstances of researching with children. In relation to the

same topic, the selection of methodologies and techniques for data collection are concordant with the idea of being appropriate for children to be comfortable during the fieldwork (for example, using ‘creative methodologies’ instead of more fixed and structured ones, such as questionnaires or long interviews)

Finally, the researcher followed the code of conduct of the National Children’s Bureau (Shaw, Brady, & Davey, n.d.). Since Chile does not have a counterpart or similar institution to the one previously mentioned, I worked under the principles expressed in the code of conduct of the Chilean Association of Psychologists (“Código de Ética Profesional | Colegio de Psicólogos de Chile,” n.d.).

Data protection

To ensure that the data produced during this research is protected, some measures were taken. During this research, the name of all the participants (medicated children, their peers, teachers, and all the others that might relate to them during the research) were anonymised. This means that in publications or situations in which this data is being shared or revealed, names were — and will continue to be — changed for pseudonyms that participants could choose or, if they did not want to, were given by the researcher. In addition, the surnames of all participants were deleted from the notes and recollected data. The process of anonymisation was coherent with the context, meaning that female names were replaced by other female names, and male names with other male names. Also, the new names given were coherent with the context of research — a school in Santiago, Chile — which entailed that the names given after anonymisation maintained coherence with the original milieu.

The names of the schools were also changed. As with the name of participants, new names were chosen that kept a close relation to the originals — inspired by the Catholic tradition which is common to encounter in high-income schools of Santiago. Only general and vague references about the schools’ location are given in this thesis, as a specific location in Santiago can give away easily the identity of these schools. After all, the location of schools in Santiago can easily give away the identity of the schools for people who are familiar with the city. And along with the identity of the

schools, it is possible to guess the kind of students attending these schools, their lifestyles and also the expectations about how children should act, behave and perform from their parents, school and peers (Ruiz-Tagle & López M, 2014; Sabatini, Cáceres, & Cerda, 2001).

During the process of research, field notes were taken and a personal diary was also used. Field notes were collected by putting together different things, such as jotted notes written in the field, which were kept in a special fieldwork notebook; direct observation notes, written after leaving the field; inference notes, related to interpretations about what was witnessed in the field; the researchers own emotions and thoughts about what was happening in the field, which were recorded in a personal journal, amongst other sources. All the information recorded in the field in a non-digital format was kept safe, under lock in a cabinet of my personal desk until digitalised. Once digitalised versions were obtained, the original sources — journals, notebooks, pieces of paper, etc — were destroyed.

Interviews with teachers and other individuals working in the schools were recorded with a digital tape recorder. The information obtained was transferred within 24 hours of the interview to my personal computer. After the information was backed up on the computer, the audio tracks were erased from the digital tape recorder.

Any information stored in digital format was encrypted. This applied to all information stored on my personal laptop, pendrive, mobile, or any other similar devices. No information was stored in any online storage system such as Dropbox, Icloud or similar, because of the potential risk that entails.

As a postgraduate research student at King's College I followed the King's College Data Protection (Personal Information Management) Policy, which is in compliance with the Data Protection Act 1998. This entails that I had to obtain consent from research participants to process their personal data for fulfilling this research project as well as future publications. In addition, I only collected and processed personal details which are necessary for the completion of this research study, and retained audio recordings of interviews only as long as necessary in order to transcribe and anonymise them, after which they were permanently destroyed. All other data will be held for 3 years and 3 months, after which point it will be destroyed.

Chapter 3¹²

The Chilean milieu: socio-cultural, epidemiological and historical review of the Chilean context

Understanding childhood in Chile and engaging with Chilean children

Introducing stimulant medication in Chile and the birth of the necessity of medical treatment: discursive discontinuity and the need to build a history of ADHD

Educational and policy changes around ADHD: the hype of stimulant medication

Where are we today? Current trends and figures of consumption and their relation to ADHD

Conclusions

In this chapter, I introduce the reader to some of the particularities that Chile presents when it comes to reflecting upon the interconnections between stimulant medication and children's actions, behaviours and experiences. During this chapter I argue that Chile presents characteristics which makes these interconnections particularly interesting to explore. It is possible to find in the Chilean context a newly generated public awareness and concern regarding the use of stimulant medication which has increased during the last decade. This is in line with reports placing Chile as one of the leading countries when it comes to consumption of psychotropic medication such as psychostimulants, currently being ranked amongst the top ten according to data provided by the International Narcotic Control Board (International Narcotic Control Board, 2013). However, and in contrast to other leading countries in this matter, such as the US, Chile lacks research and studies into the real impact and scale of stimulant medication. Little research has been conducted to understand the meaning of these rates, or how they translate to the everyday lives of consumers, especially children.

¹² Some parts of this chapter are based on a previously written book chapter titled 'From problematic children to problematic diagnosis: The paradoxical trajectories of ADHD in Chile' in which I am the main author. It is expected to be published during 2018 in the book 'Global Voices of ADHD', edited by Peter Conrad, Ilina Singh, Angela Filipe and Meredith Berger. John Hopkins University Press.

While international agencies have made some attempts to produce epidemiological data about the consumption rates of stimulant medication in Chile, for unknown reasons there have been no national attempts to do the same. As I discuss in the following sections, most of the data available that has been produced in Chile is either incomplete, partial or considered as non-validated by other Chilean experts. This makes even more urgent the need for more research to be conducted in Chile about children, with an emphasis on how they live and experience their everyday lives and realities. This call for action is sustained not only in the need to produce ethnographic data, but to amend a more general neglect in Chile when it comes to understanding children's mental health and lived experiences, an area where there is only scarce epidemiological data and few studies, as I will discuss in the following sections. There is a need to understand the national trajectories of biomedical models and labels, highlighting the sociomaterial factors involved in their shaping and in how they circulate in the social imagination.

When it comes to the rise in the use of stimulants by children, it is necessary to understand that this is closely linked not only with the introduction of biomedical models and technologies for understanding children's actions and behaviours, but that this increase in consumption is also linked to political and cultural reforms, particularly to the restructuring of the educational system, which is suspected to have led to children being medicated more frequently than before (Ceardi et al., 2016). It goes without saying that the rise experienced in children's use of stimulant medication was not something planned or aimed at when these policies were originally crafted. However, the way in which these policies have been framed, particularly through giving economic incentives to schools for including children diagnosed with ADHD and other disorders, has facilitated access to stimulants as a way of dealing with school difficulties.

In this chapter I explore how these dynamics have been contested recently by various social actors, who have employed arguments first used by social scientists and others to denounce the medicalization of childhood, opposing what they consider to be an unleashed proliferation of both the diagnosis of ADHD, and the use of stimulant medication. Therefore, and in line with understanding how children and stimulant

medication meet in the classrooms of schools Mount Sinai and Bethlehem, an understanding of the broader picture is required, one that allows the reader who is unfamiliar with the Chilean context to first understand how sensitivities towards children are currently being displayed in Chile. After all, as has been discussed at length by the new social studies of childhood, the experience of being a child changes from place to place, according to the set of relationships and sociomaterial factors that children have to engage with (Prout & James, 1997). In that sense, it becomes necessary to understand previous and current conceptualisations of children in Chile, and how educational policies, medical breakthroughs and different actors have shaped the field in such a way that the nature of children's lives has become a matter of fundamental concern, although not much has really been done about it. It is only by understanding how these different dynamics interact that, later on, it becomes possible to understand how they get translated into the classrooms in manifold ways, animating particular understandings and relationships between children, medication, and other actors.

Understanding childhood in Chile and engaging with Chilean children

What is it like to be a child in Chile? Is it possible to build up a unified vision of what a child is like, or about how they feel and think regarding their surroundings? Is it even possible to say there is something as a standard 'Chilean child'? These questions may seem highly abstract and may even be inappropriate when it comes to the purpose of this research. However, as vague as they may seem, these questions are of crucial importance to start framing how to reflect upon the national context in which this research is taking place. Thus, it is necessary to address them even if there are no clear answers, and if the only thing to do is to declare that the lack of information is something to be aware of.

Childhood can be many things. Following the arguments of some leading experts in the New Studies of Childhood (James & James, 2004, 2008), it is useful to distinguish between what 'childhood' is, and what 'children' are. Childhood can be thought of as a series of social and historical institutions resulting from constant processes which attain not only meaning, but also material aspects. In contrast, children can be

considered as the actual individuals, the child as an historical actor who inhabits the space of childhood, reproducing and contributing to its transformation over time and space. The reason why this is relevant is because childhood can, indeed, be considered to be one thing, but the actual experiences of children around the country may vary enormously from place to place. This has been explored by some Chilean historians who, using a critical theoretical framework, have revealed how the experience of 'being a child' can be dramatically different according to the place and socio-economic background in which one is born and raised (Montecino, 1991; G. Salazar, 2007; S. Salazar, 2006).

The potential outcomes that a child must experience in Chile vary according to whether they are born into rich or poor circumstances, with all the possible gradations that may come in between these extremes, within what can be considered a fairly traditional society. As Valdés Subercaseaux (2008) describes, for various reasons, Chile corresponds to a traditional order:

[Chile] shows a weak porosity to the changes in private life that came along with Modernization and Modern era and it would be better described as a society characterized by a "fractured conservatism". In part, this can be explained by the delay in juridical changes related to family issues in comparison to European countries, which are delayed by approximately thirty years, while the delay is smaller in relation to other American countries. (p. 33)¹³

The dictatorship of Augusto Pinochet that lasted for almost 20 years (from 1973 to 1990) is one of the key factors that influenced this kind of conservatism, playing a central role in the establishment of policies that aimed to produce a 'conservative restoration', freezing most of the more liberal policies, and imposing economic liberalism in close relation to cultural conservatism. In addition, as Valdés (2008) mentions, after regaining democracy, the governments of 'la Concertación'¹⁴ have had

¹³ Original text in Spanish, translation mine.

¹⁴ 'La Concertación' is the name of the block of left-wing political parties that opposed the dictatorship and regained democracy in 1990. Since then, all but one President (Sebastián Piñera) have belonged to this block.

little success in detaching religious thought from State matters, which have influenced policies in areas such as adoption, childhood and family, to name but a few.

For some Chilean social scientists (Camargo Brito, 2008; Garretón, 2004; Vergara, 2014b), the different governments that have represented the ideology of 'la Concertación' have insisted that there has been a genuine social consensus regarding the process of change that has occurred since the end of Pinochet's dictatorship, although in reality this consensus is not sturdy. Until today, public policies appear to be more in accordance with a logic of continuity than one of proper change if they are compared to the model used during the military dictatorship. This, as Vergara (2014) reflects, is closely related to the fact that

neoliberalisation of Chilean society, regarding economy, the role of the state and the private sector, has remained paramount and unaltered (...) At the same time, important areas of social policies were privatised and mechanisms of co-payment introduced, not only during the dictatorship but also during the Post-Authoritarian Democracy. The quality of services offered to poor sectors when compared with those available to the middle and upper classes continues to be deficient. The striking contrasts in the quality of life of children from different socioeconomic backgrounds have remained. (Vergara, 2014b)¹⁵

In addition to the traditionalist ethos to be found in Chilean society, the absence of major reforms of public policies, the strong economic neoliberalisation and other key elements that remained as heritage of the military occupation of the government, there is one more central feature to be highlighted, which is deeply related to the way in which childhood is thought of, at least in an official way. By this, I refer to the way in which childhood is represented and dealt with in terms of governmental policies and practices.

Children's developmental needs, as they are expressed in the 'Política Nacional a favor de la Infancia y la Adolescencia 2001-2010'¹⁶ are framed in such a way in which they are thought to be natural and intrinsic to children. A-historically and a-culturally situated, children's needs are presented to be universally equal, disregarding differences between cultural, historical and social contexts (Vergara, 2014). The very

¹⁵ Original text in Spanish, translation mine.

¹⁶ 'National Policy in favour of Childhood and Adolescence'.

idea of a universally and naturally constituted notion of what children are has been strongly criticised by a vast array of researchers interested in children's lives, because of its blindness to diversity, cultural determinants and social shaping of childhood (Christensen & James, 2008; Lee, 2001, 2005; Prout, 2005).

Particularly troublesome in the Chilean context is the increasingly popular idea of children as 'closer to nature' than adults, which is consistent with Jenks' (2005) articulation of what he calls the 'Apollonian child': viewed as a pure and innocent creature, untainted by society's shortcomings and flaws. In Jenks' words, 'Children under this scope are beaten into submission, they are encouraged, enabled and facilitated' (p.73). This idea of a certain purity in children's behaviours and actions, which is increasingly getting stronger amongst families with children with learning difficulties or children under medication, often clashes with the formal imperatives established by the educational and health system, which strongly suggest and at times advocates in favour of a biomedical understanding of children's actions and (mis)behaviours, and is reflected in the increasing rates of consumption of stimulant medication that targets school-related behavioural problems (International Narcotic Control Board, 2013).

This increasing tension between more school-related diagnosis and biomedical treatments, and a growing unrest regarding the same, is now part of the landscape which children face as part of their everyday life. The contrast between both approaches may be explained by the fact that different logics underline each approach. On the one hand, as reflected also in the above-mentioned 'Política Nacional a favor de la Infancia y Adolescencia 2001-2010', the government mainly perceives children as human capital, being in need of social investment to make a positive (economic) contribution to society. This idea finds its origin in the dictatorship, but as Vergara (2014a) observed, has been reinforced during the post-authoritarian democracy. On the other hand, individuals have reacted against the idea of reducing children merely to human-capital by expressing their reservations towards biomedical diagnosis and the effects of the medications, questioning the importance and benefits that medication can provide, and sharing these thoughts and reflections on different social media platforms (Becerra, 2013b; Ramírez, 2013).

However, this is only the latest development in a long and largely unknown history of stimulant medication and its relationships with several other factors, as far as it is possible to witness these in the particular framing provided by the Chilean context. To fully understand the complex relations that individuals have established with stimulant medication, it is necessary to explore the historical developments and actors that have rendered this interaction the way it currently is. As expected, the history of stimulant medication is closely linked to the history of ADHD, both having troublesome histories that are fragmented, partial and mostly unexplored in Chile (Rojas Navarro et al., 2017).

Introducing stimulant medication in Chile and the birth of the necessity of medical treatment: discursive discontinuity and the need to build a history of ADHD.¹⁷

The history of stimulant medication in Chile is connected since its origins to the history of ADHD. However, the first complication arising when following the different paths traversed by stimulant medication is that both its origins and those of ADHD in Chile are blurry and mostly undocumented. In describing ADHD and how this disorder came into being, the history told by Chilean articles and experts normally refer to what can be called as the ‘global history of ADHD’, like the one narrated by Russell Barkley (2005) or by Rick Mayes and his colleagues (Mayes et al., 2009), who emphasise a trajectory from the discoveries made by George Still in 1902, to the coining of the name ‘Attention deficit/hyperactivity disorder’ in 1987. But this history is not a local one: no reference is made to when, how and why ADHD emerged in Chile. In other words, the history used to understand ADHD and the surge of increasing stimulant medication use is one that is being borrowed from external accounts, one that pays no attention to

¹⁷ This part of the chapter is mainly based on a contribution I wrote, with two other colleagues, for a book on *Global Perspectives on ADHD*. The original chapter, in which I was the lead author, has been slightly modified for use in this thesis. What is being used for this purpose are the ideas and paragraphs in which I can claim that I was the leading voice, with the arguments and ideas used of my ownership. However, it is always difficult to estimate to what extent others influence the development of an idea, especially when working with long-standing colleagues. For that reason, I have edited some of the original arguments to reflect more fully my own points of view. In addition, I would like to thank my colleagues and friends Mónica Peña and Patricio Rojas, who co-authored the original article.

our national particularities, to our cultural manifestations, or to our contextual determinants.

Considering that the history of stimulant medication in Chile has been linked since its very beginning to the diagnosis of hyperactivity in children, it is difficult to trace the history of former without taking into consideration the trajectories of the latter. Therefore, and in consequence of the lack of information exclusively linked to the introduction and uses of stimulant medication on national soil, it is necessary to start from the diagnosis and, from there, reconstitute the history of the medication. So, I will start by attempting to construct the history of ADHD, which I will show is a crucial step to understanding how the medication has played different roles and has ended up in its current position in Chilean society. Considering the lack of robust sources of information about this topic, I aimed to produce a patchwork, a product of carefully putting together different pieces which initially may appear to have little in common, but which, when crafted together, allow a broader picture to emerge, in this case, one related to stimulant medication and the different trajectories that it has covered in Chile over the years. This patchwork was made after consulting several references and interviewing some of the key actors related to ADHD in Chile. This is not an 'official history' of ADHD in Chile, although I follow the most relevant trajectories that the disorder has taken during the last 50 years.

It is important to acknowledge that what I am about to describe does not necessarily reflect my own position regarding the topic. I believe that the rise in stimulant medication consumption is a cause for alarm, as are the current prevalence rates of ADHD in Chile. However, I do claim that stimulant medication effects are not auto-effective, and depend on the ecological niche where they are being deployed. They can even, at times, entangle with medicated children, helping them to overcome difficulties by enabling new achievements. However, none of this comes without the objectification of the child to some extent. There is more to how medication works than the universal and culturally-independent effects narrated by those claiming that are only devices for social control. I concur with Charis Thompson (2005) in reflecting that in some cases, by becoming objectified by the biomedical apparatus, children can achieve long-term gains. In this case, the use of stimulant medication as the outcome

of being objectified by medical discourses can produce positive effects. In Thompson's words '(...) it is possible to discern potential gains for the long-range self within each dimension of objectification, even when there is a notion of agency that is commonly opposed to the dimension in question' (p. 599).

I will return to Thompson's idea when analysing the findings and results obtained during my fieldwork. But, for now, I intend only to stress that the history of stimulant medication that I will reconstitute below reveals the changing position of different social actors in Chile, none of which is necessarily my own standpoint. As discussed in this chapter, it is still common to run into opposition from those who apparently support the use of medication without reflecting further about it, its consequences or potential effects on children, as well as from those taking the opposite view, arguing that Chile is becoming a society in which adults 'drug their children' to control them and so that they achieve educational success (Becerra, 2013b), ideas imprinted by notions of social control and the medicalization of deviance. I aim only to reconstitute this dispute to follow the history of the uses of stimulant medication in Chile.

To the best of my knowledge, the earliest mention of stimulant medication in Chile is related to its entrance into the national medical milieu around 50 years ago. Methylphenidate started being commercialised under the name 'Ritalin' by the pharmaceutical company Ciba in the United States in 1955 (Mayes et al., 2009), and found its way into Chile in the 1960s. According to reports gathered by the historian Jorge Rojas, the entry point for the medication was the 'Servicio de Psiquiatria Infanto Juvenil'¹⁸ located at the Luis Calvo Mackenna Hospital. That specific ward had contacts in Argentina, who fostered and helped to bring the medication into Chile as a way to treat hyperactive children. However, Ritalin was not an instant success, and it took time for its use to widen and become accepted (Rojas, 2010).

Not much was written or said about Ritalin or stimulant medication until the 1980s. By then, Ritalin started being frequently used, becoming one of the most common ways to treat not only children whose behaviour matched the criteria for diagnosing ADHD, but also for treating children with problematic behaviours which, however, drifted

¹⁸ Psychiatric Ward for Children and Adolescents

away from the diagnosis: children labelled as 'weird' or 'problematic' also started being treated with Ritalin (Rojas, 2010). Lurking beneath the widening field of action for Ritalin seemed to be some sort of miscomprehension or misdiagnosis when evaluating children, the result being that children lacking a diagnosis warranting the use of stimulant medication started to be treated with Ritalin to attempt to control certain behaviours that can be encompassed under the label of 'deviant'. What was at stake was an opposition between what was expected of children, and how they actually behaved in practice. This is an important thing to note regarding the relationship between stimulant medication and children in Chile. The medication was quickly put into use not to treat a specific diagnostic category, such as ADHD, but a set of behaviours and way of being. Of course, children with ADHD fitted the required characteristics for medical experts to recommend the use of Ritalin in Chile, but the use of the drug back then was not restricted to children diagnosed with ADHD.

This is reflected in media articles from the time. One example can be found in the magazine 'Revista YA'. This magazine, first published in 1981, is still distributed on a weekly basis along with one of Chile's main newspapers, 'El Mercurio', and is aimed at a particular type of reader: middle and upper class women. Most of its articles are about motherhood, style, sports, and activities expected to be appealing to adult women.

During the 1980s, it was common to find articles referring to different clusters of children. For example, a child psychiatrist who used to write a column for the magazine, Hernán Montenegro, stated that 'during the development [of the child] these characteristics [attention, activity level, adaptability, among others] can increase or decrease (...) According to how they fit together, there are three types of children. Easy-going, difficult and slow children' (Montenegro, 1983a). The same psychiatrist adds in another column how parents might find it more difficult to accept the behavioural or learning disorders of their children, than to accept conditions such as mental retardation, or some paralysis. This is because parents have to deal with the fact that despite 'the boy (sic) [for whom the parents are consulting a medical specialist] being physically and intellectually normal and "having received the same

[caring and opportunities] as had been given to their other children", might be so different' (Montenegro, 1983b).

The opinions of Montenegro reveal a certain ethos of the time, helping to visualise the position given to what was understood as an ADHD child in the 1980s: troublesome enough to state that it was easier to deal with a child who had 'mental retardation' than with them. This ethos can be found in the biomedical literature about ADHD and in how schools started to deal with diagnosed children. According to articles published in 'Revista YA' (Araya, 1987b; Galvez, 1995b), schools were key actors in identifying the disorder, becoming the most concerned about the necessity to be aware of and treat the disorder as quickly as possible. This was driven by the fact that the potential outcomes of ADHD at the time were expected to clash against what was needed for children's academic success. The literature described multiple possible outcomes for children with ADHD in the 1980s, which ranged from becoming adults with low job stability and a higher rate of divorce, to a lower educational level. Because of that, the premise for treating them was always 'the sooner the better' (Araya, 1987b). Schools have continued to play a crucial role in the current shaping of ADHD and the use of stimulant medication, as I discuss further below.

Chilean historians such as Jorge Rojas (2010) claim that the 'boom' of ADHD and Ritalin consumption occurred in the middle of the 1980s when, according to reports he gathered, it was common to see empty boxes of the medication discarded on the ground of low-income neighbourhoods of Santiago. For others, it was in the early 1990s when the use of Ritalin peaked (Jaque & Rodríguez, 2011). Either way, there is a shared understanding that the 'boom' of ADHD led to an excessive use of medication as the main way to tackle the condition.

Juan Sepúlveda, current lecturer of Child Psychiatry at the Medical School of the Universidad de Chile, remembers that until the late 1980s the trend among medical practitioners was to use amphetamines to treat behavioural issues. He also recalls how the use of medication — amphetamines, and later on methylphenidate — was considered by most of the population and medical practitioners as the path to follow: 'For the population, the use of medication was a solution that served everyone, since it avoids questioning anyone about their parenting style or any other aetiological

possibility not treatable with medication. There was no opposition to this way of procedure. Even more, it was appreciated by everyone' (personal communication, July 2014). Still, what was being treated was not a unified medical entity. The descriptions of who should visit a medical practitioner and the reasons to do so varied across time. Nevertheless, descriptions of these children commonly used words like 'public danger', and 'unbearable' (Araya, 1986), or 'restless', 'obstinate', and 'haughty' (Ruiz, 1985). Looking back at the history of ADHD in Chile, experts seemed to have no consensus regarding what was supposed to be at cause (Araya, 1987a, 1987b; Ruiz, 1985). Regardless of the lack of clarity about the causes, or the 'real' effects that the medication could produce, use of the notion of ADHD spread through Chilean society, and by the 1990s, it had become a major diagnostic trend in child psychiatry, psychology and the educational environment.

Media articles reveal that by the beginning of the 1990s it was customary for schools to ask parents to take their children to the neurologist as a result of their behaviour at school (Jaque & Rodríguez, 2011). By then, Ritalin had become the most accepted way to treat children who were 'difficult' and had a hard time focusing during class, or remaining still in the classroom. This put parents in an awkward position, revealing of the confusing scenario surrounding ADHD and its treatment at the time. The mother of an 'ADHD child' interviewed by reporters José Miguel Jaque and Francisco Rodríguez (2011) remembers that 'there was a controversy. It was said that [Ritalin] turned children dumb, that it was being overused and that scared me'. At the same time in Chile, prospects for children with ADHD who did not use Ritalin were framed as catastrophic: 80% of the children would not 'outgrow' the disorder, 30% failed at school, 24% would become alcoholic. Considering this, it does not come as surprise that Ritalin became some kind of 'magic bullet', which held the promise of dealing in an immediate way with these 'annoying, relentless and intolerable' children (Jaque & Rodríguez, 2011).

It has been argued that the multiple — and not always rigorous — ways to diagnose ADHD, along with the lack of reflection in relation to the condition, and the indiscriminate use of Ritalin, ended up shaping what during the 1990s was called as the 'Ritalin generation'. This is a generation of children who grew up being considered

as problematic, being stigmatised during their school years, and described as impossible to deal with by their educators and peers (Jaque & Rodríguez, 2011). The process of stigmatisation of these children can be attributed to two overlapping processes. First, by the beginning of the 1990s, the existence of the disorder was still mostly unrecognised in education. For educators and teachers, what was being observed inside the classrooms was not necessarily a biomedical disorder. What they observed was behaviour without a certain cause: relentless movement that needed to be tamed and controlled by any possible means. This led to the use of certain practices inside classrooms which ranged from humiliating the child in order to make them stop disturbing others, strapping them to their school desk, or even locking them inside a closet (Jaque & Rodríguez, 2011). The second overlapping process was the popularisation of Ritalin as a way to stop children from misbehaving. Ritalin enabled children's actions to be linked to a biomedical cause under the rationale that if a pharmaceutical drug produced an effect on children's behaviour, the cause of the behaviour had to be a biological disorder, despite its unclear origin.

By 1995, it was estimated that 5–10% of Chilean children had been diagnosed with ADHD (Galvez, 1995a), and even a larger percentage of children had been taken by their families to medical experts, looking for advice and medication. Carlos Acevedo, a neurologist interviewed about the subject by a reporter of 'Revista YA', mentioned that the increasing rate of children diagnosed with ADHD and using Ritalin was related to a sum of elements: schools becoming stricter, classrooms becoming more populated and teachers less flexible and tolerant. In addition, children had to deal with more distractions in their everyday lives, such as television, and they also encountered fewer control mechanisms, considering societal changes such as both parents having to work outside the house (Galvez, 1995a). However, having been object of a biomedical diagnosis did not prevent the situation that most of the time children with ADHD were discriminated against at schools, to the point of being punished if they did not take their medicine. Some parents felt like they were being forced to medicate their children, such as Soledad, mother of a child diagnosed with ADHD who was interviewed by 'Revista YA' in 1995:

I think it sucks that he has to take Ritalin, but at the same I realized that it had helped him. Moreover, if I consider that he should take more in order to

prepare for his school assessments, I should give him more, but I refuse. Maybe it is foolish, but I am not convinced about giving him so much stuff (...) now they [schools] send them [children] to the doctor for any reason. I don't have any family members whose sons have not been sent to visit the *psicopedagogo*¹⁹. If he [the child] is active, they immediately say that he is hyperactive and it turns out that children are normally supposed to be like that [active]. Maybe it is that some schools are now taking distance from the problem... (Galvez, 1995b)

Discomfort with how schools were addressing their children was the main reason triggering the founding of ANPANDA, the National Association of Parents of Children with ADHD, and a series of educational policies which aimed to tackle how ADHD children, along with children with other learning difficulties, were to be dealt with in schools. Both helped to shape the current state of ADHD in Chile by modifying the core elements involved in its handling in schools.

Educational and policy changes around ADHD: the hype of stimulant medication

As mentioned above, a close relationship has been suggested between the increasing numbers of children diagnosed with ADHD, the increasing numbers consuming stimulant medication, and the role played by schools in the process of referring and diagnosing children in accordance with the way in which children act and behave at school. But to understand how ADHD became entangled in relations with the institutional setting of the school, it is necessary to contextualise the way in which Chilean education has been governed in the recent past. To do so I will show how changes in policies concerning education and childhood have affected the way in which diagnosis, medication and children interact inside schools. Most of these policies, as I will show below, are part of the heritage left behind by the military dictatorship that ruled Chile for almost twenty years, while other policies are considered to be the result of the incapacity of the democratic governments to make a clean cut with that moment of Chilean history.

¹⁹ *Psicopedagogos* are professionals that blend together psychological theories about the learning process of the child, theories about education and about developmental biology. Normally, they work with children who exhibit learning difficulties or cognitive impairment.

Chile was ruled by the military dictatorship of General Augusto Pinochet for almost twenty years, from September 1973 when, by force of arms, he substituted former president Salvador Allende, who was killed during the military uprising. Pinochet's dictatorship ended in 1990, leaving behind a series of modifications which directly affected the legal constitution of the country, while promoting several policies influenced by the extreme neo-liberalism of the 'Chicago boys', namely, a group of Chilean economists and intellectuals forged in the School of Chicago under the direct influence of Nobel laureate economist Milton Friedman (Cypher, 2004).

In relation with these modifications, in 1980 the Chilean military dictatorship introduced choice in education as part of a neoliberal reform, dramatically changing the former education system provided by the state. The cornerstone of the reform was the implementation of a voucher system, which could be used in both public and private schools. Today, 92% of the Chilean students use vouchers (Elacqua, 2012). The consequences of the implementation of this in policy are discouraging: the voucher system has not improved students' performance in standardised tests, nor it has diminished their academic failure. Furthermore, the result has been a significant segregation between children attending private schools, and the ones attending either public or partially government-subsidised schools (Hsieh & Urquiola, 2003).

Due to segregation and its effects on low income children, a change was implemented in 2008, when the Congress passed an adjusted voucher bill called 'Ley de Subvención Escolar Preferencial' or 'SEP'²⁰. Through this law they increased the amount included in the voucher for students who are considered as 'vulnerable' because of their socioeconomic background. In other words, the SEP voucher considered that it is more difficult and expensive to educate students from low socioeconomic status. The SEP law does not change the essence of the voucher system. In 2005, long after Pinochet's dictatorship, President Ricardo Lagos sent to the Congress the bill that created SEP: 'To pretend that everybody has to receive the same when their needs are different is to discriminate', wrote Lagos in the message to the Congress explaining why he was ending 'flat vouchers' to decrease inequality of opportunities (Lagos, 2005).

²⁰ Law of Preferential School Subsidy

In 2010, during President Michelle Bachelet's first term as head of state, a new educational finance law called 'Decreto 170' or 'Differentiated grant for special educational needs' was implemented. This decree follows the same principle as the SEP law mentioned above: to increase the subsidy for those children who have a problem that prevents them from continuing their education in a 'normal' way and, therefore, require special financial support. This additional economic support aimed to promote the hiring of special education teachers and psychologists who might oversee supporting the educational process of these 'problematic children/cases'. A crucial issue in relation to this benefit is that, for the school to get access to this grant, children must undergo a process of diagnosis, which should be performed by a physician. In concrete terms, the grant a school receives for a diagnosed child is triple that of an undiagnosed student. The specialists authorised to diagnose children must be approved by the Ministry of Education (in practice, having a professional degree is enough) and, given the parents' 'right to choose', they can resort to a private practitioner or, in some cases, the community health care centre.

For Decreto 170, a student who has special educational needs recognised by the law is one that requires additional help and resources, whether human, material or pedagogical, to enhance their development and learning, and contribute to achieving the goals of education. The decree mentions two different kinds of 'Educational Needs': those which are considered to be *permanent* (including autism, severe intellectual disability, visual and hearing impairment, among others); and those framed as "*transitory*", i.e. non-permanent needs that students face at some point in their school trajectories as a result of a disorder or disability 'diagnosed by a competent professional and in need of extra help and support to access or progress in the curriculum for a certain period of their schooling' (Decreto 170, 2009). Thus, specific language impairments, 'performance on IQ tests in borderline range, with significant limitations in adaptive behavior' and ADHD became the diagnoses considered for the special voucher (Decreto 170, 2009).

The effects of this policy have not been officially evaluated. One of the few attempts to assess the decree was made by an employee of Valparaíso's Educational Bureau, and tries to give an account of the diagnosis processes carried out under the 'Decreto

170' during the 2011–2012 period in first grade students (Torres, 2013). The study shows that the prevalence of ADHD diagnosis ranges between 8–9% of the total amount of diagnosis of students of primary school. Something similar is stated by other researchers, who argue that since the promulgation of 'Decreto 170' in the 2011-2012 period, the amount of children diagnosed with ADHD in the Metropolitan Region — where Santiago is located — who matriculated in schools went from 2.723 to 8.339. This is a 306% increase in one year (Ceardi et al., 2016). In addition, studies such as the one conducted by Torres reveal how since the implementation of the 'Decreto 170', most children with special educational needs end up in public schools, while private or partially private schools (that is, schools which are co-founded by the government via municipalities, and by the parents of children attending those schools) seem more reluctant when it comes to receiving this kind of child in their classrooms. This is concerning, particularly because public schools not only present a much bigger quantity of children with learning impairment, but also the diversity of diagnostic categories is much wider. As Torres reflects, this is something to worry about, particularly since the international evidence reveals that the countries with the highest standards in education normally are those which lack big gaps or differences amongst schools and classrooms, in terms of the content and inclusivity of schools (Torres, 2013).

The same department that formulated the 'Decreto 170' also published in 2009 the 'Guide for understanding and developing strategies to support the ADHD from an inclusive approach' (Ministerio de Educacion [MINEDUC], 2009). This document, strongly embedded in the rationale and diagnostic categories provided by DSM-IV, despite never explicitly mentioning it, aims to serve as a guideline for dealing with children diagnosed with ADHD in the classroom. Since it is embedded in the DSM-IV categories and rationale, this document suggests two different but not necessarily exclusive approaches: on the one hand, it recommends individual work focused on the students' self-esteem, their possibilities and/or the special features that the teacher should have — or develop — to work with children presenting special educational needs. On the other, the strategies prompt work in the classroom and the school in general. This includes actions upon aspects such as the classroom climate, the 'internal' organisational school relationships and especially the relationships between the

‘ADHD child’ and their peers and teachers. Thus, the document rather operates more as a broad description of the problems and possibilities of ADHD children than an actual strategic guide for promotion/intervention. However, it insists on the importance of the integration of children, their educational possibilities and special needs. This is particularly interesting. Despite criticisms by lay people and critical social scientists, it is possible to witness how for the few governmental documents related to ADHD, pharmaceutical interventions are something to be taken seriously. Treatments and interventions in relation to children diagnosed with ADHD are constantly remarking on the importance of the ecological niche of the ADHD child, although in practice these warnings seem to be mostly overlooked or not taken seriously enough, as can be inferred from the high number of children under pharmaceutical treatment. However, different schools react differently to the treatment, and they also provide different pedagogical and academic alternatives for medicated children, as will be discussed in the next chapter.

Where are we today? Current trends and figures of consumption and their relation to ADHD

As I mentioned earlier, it appears that the introduction of some policies concordant with the proclamation of the ‘Decreto 170’ played a key role in the current shaping of ADHD in Chile, and even though awareness about the disorder has grown among lay people, media and experts, it is still difficult to find figures, rates and/or studies about the subject. It is because of this lack of coherent information and poor planning that in order to have an idea of the current state of ADHD in Chile, it might be useful to approach the subject using an alternative method, such as constructing a patchwork composed by pieces of information obtained from different sources and by different actors, in an attempt to gain a broader understanding of the different dynamics and actors involved.

Going back to the official or centrally generated data, the first one provided by the Chilean government was made official in 2008, when the ‘Ministerio de Salud’ proclaimed that the national prevalence rate of ADHD was 6.2% (Ministerio de Salud (MINSAL), 2008). However, the same guideline also mentions that this rate was liable

to change since different methodologies would probably arrive at alternative results. Alternative information that I obtained by appealing to the Chilean Transparency Law — which grant any citizen access to governmental data — revealed that during the years 2009–2013 the number of individuals aged 19 or under being treated for ADHD in the public health system almost doubled, rising from 27,659 in 2009 to 52,895 in 2013. The most affected age group is the one ranging from 10 to 14 years, which has seen its number rise from 9,700 in 2009, to 20,018 in 2013. Over 50% of the people receiving treatment in the public health system were diagnosed and treated in the Metropolitan Region, which contains almost 35% of the total country’s population. In addition, it is important to emphasise that these rates include only people using the public health system, excluding those using private healthcare, as this information cannot be accessed through the same way and is kept from the public.

Table 1: Figures provided by the Chilean Ministry of Health under the title ‘Population currently attending programmes of mental health, figures of individuals diagnosed with Hyperkinetic, Activity, and Attention Disorders’ in the Metropolitan Region. These figures include all ages.

	Female	Men	Total
2009	3,875	12,244	16,119
2010	4,695	14,763	19,458
2011	6,102	18,386	24,488
2012	7,813	20,522	28,335
2013	8,307	21,925	30,232

Table 2: Figures provided by the Chilean Ministry of Health under the title ‘Population currently attending programmes of mental health, figures of individuals diagnosed with Hyperkinetic, Activity, and Attention Disorders’ in the Metropolitan Region. These figures include only individuals aged 19 or under.

	Female	Men	Total
2009	3,861	12,220	16,081
2010	4,673	14,743	19,416
2011	6,072	18,360	24,432
2012	7,770	20,480	28,187
2013	8,260	21,859	30,119

Table 3: Figures provided by the Chilean Ministry of Health under the title ‘Population currently attending programmes of mental health, figures of individuals diagnosed with Hyperkinetic, Activity, and Attention Disorders’. Comparison between people diagnosed and attending public health programmes in the Metropolitan Region, and in the rest of the country.

	Metropo litan Region	Rest of the country
2009	16,119	11,632
2010	19,458	14,783
2011	24,488	17,559
2012	28,335	20,986
2013	30,232	22,955
Total	118,632	87,915

Undoubtedly linked to the increase in the rates of diagnosis, data provided by the ‘Central de Abastecimiento del Sistema Nacional de Servicios de Salud’ (Centre for Provisioning of the National System of Health Services) reveals that the amount of money spent by the Chilean Government on methylphenidate doubled from 2011 to 2012.²¹ The International Narcotic Control Board (INCB) has placed Chile into the top ten countries in the world for consumption of methylphenidate, with a stated demand of 400,000 grams in 2013. This places methylphenidate as the second most demanded psychotropic substance by the Chilean government (International Narcotic Control Board, 2013).

The growing tendency to diagnose more, and to use more medication such as methylphenidate, has raised concerns among some social actors involved in the process of diagnosing and medicating children with ADHD. However, it is only during the last couple of years that the mass media, such as newspapers and radio stations,

²¹ Figures and data obtained via Chilean Transparency Law.

have openly started to criticise these trends and make claims about the possibility that either ADHD does not really exist (Yañez, 2014), that the condition is probably overdiagnosed (Becerra, 2013a; Charpentier, 2013), or that Ritalin is not an effective treatment (Becerra, 2013a; A. Christiansen, 2013; Ramírez, 2013).

In Chile criticisms of the use of stimulant medication and the high numbers of diagnosed children consuming stimulant medication are normally not restricted to a criticism of the medication, but also contest the diagnosis itself. Criticisms of either the stimulant medication, the diagnosis of ADHD, or both are normally driven by the same fears that have been common amongst lay people for decades, and that were summarised by the historian Jorge Rojas (2010) in the following way: uncertainty of possible side-effects, dependency on the substance, and neurological damage, among others. Even though these fears have been dismissed by a clear majority of Chilean experts on the subject, it is not hard to find literature about the topics that concern parents on Chilean websites and online social platforms such as Facebook pages, or the comment section in online newspapers. Normally, these reports criticise the role played by the education system, school teachers, child psychiatrists and neurologists in rendering and sustaining a fictional epidemic, or in diagnosing and medicating normal children. Contesting biomedicine and the rational used for performing the diagnosis and conducting their medical procedures, some parents have started treating their children with 'traditional medicines', self-healing techniques and naturalistic approaches (Rojas 2010). Although interesting, the influence of these groups is still mostly anecdotal. The use of pharmaceutical stimulants has continued to become more and more common in Chilean schools. According to the Chilean psychiatrists and ADHD expert Amanda Céspedes, nearly 9% of Chilean children are currently consuming Ritalin in schools (Educarchile, n.d.), which places Chilean schools on a par with those in the United States (Schwarz & Cohen, 2013). But, in contrast to the US and other nations where research has been conducted to explore the causes and possible outcomes of these tendencies, in Chile this discussion is still to be had.

The apparently widespread practice of treating ADHD mostly with stimulant medication could be considered surprising, particularly considering that the guidelines provided by the Chilean Government clearly promote the idea that the treatment

should be conducted simultaneously with other therapeutic actions, trying to produce an 'ecologically grounded' approach to the disorder (Ministerio de Salud [MINSAL], 2008). This means that stimulant medication such as methylphenidate should not be used indiscriminately. Its use should be limited, being included into a more complex approach to the disorder which should also include psychological, educational and social approaches and interventions. Likewise, its use should be stopped and reassessed every year. The risks regarding the use of methylphenidate are such that the Chilean Institute of Public Health launched an 'alert campaign' in 2009, warning about the potential risks linked to the abuse and misuse of the medication.

Besides the data mentioned above, little is known about the prevalence of the disorder or about consumption rates of stimulant medication. Only a couple of studies have treated the topic, and only in a peripheral way. In 2004–2005, the World Health Organization (WHO) conducted in Chile the 'Global School Student Health survey', which included one question regarding the use of Ritalin by children during the previous 12 months before the survey was implemented. It is noteworthy that 8.3% of children aged 15 or under reported being treated with Ritalin. This figure is based on the answers of 2100 children in the Metropolitan Region.

In 2012, UNICEF conducted a study on child abuse called 'Cuarto estudio de maltrato infantil'. The survey was focused on children who, at the time of the survey, were attending the 'octavo básico'.²² Of 1,555 children surveyed, 14.7% reported having taken medication to improve their performance or behaviour. Among the medications used, stimulants such as methylphenidate and other substances used to treat ADHD were mentioned (UNICEF, 2012). According to the study, children are consuming medication not because it is necessary, but because their parents give it to them to improve their performance or behaviour. The study does not acknowledge whether there is a matching diagnosis justifying the use of medication, but it can be inferred that the most probable scenario is that the figure is not related to a medical condition, since the figure is given under the wider description of one of the possible types of violence that children in the Chilean context are being exposed to. This was a national

²² Octavo básico is the last year of what is known in Chile as 'basic education'

survey, conducted using a randomised probability sample and held to be representative of the Chilean context regarding the topic of child abuse.

As seen above, the interest in the topic is sustained and exploration thereof is encouraged mainly by international agencies. In fact, it is because of their intervention that data regarding the subject has been produced. In contrast, children have not been fully considered in research and surveys led by national medical experts. For example, the official national survey conducted by the Chilean Health Ministry, called 'Encuesta Nacional de Salud' (National Health Survey) considered as valid participants only individuals aged 17 or more. A new version of this survey which includes children is supposed to be launched in the future. The National Health Survey for Children will aim to include a group of questions about the use of medications, but there is still no specific date for this survey to be launched, according to Paula Margozzini (personal communication, March 2014).²³

Only recently, in 2013, results from the first extensive epidemiologic study in relation to ADHD in Chile were released. The study contained a sample of 1558 children and adolescents from four different regions aged from 4 to 18 years old. This is the largest study ever conducted nationally. The results show that the prevalence of the diagnosis of ADHD in Chile is around 10%. In children aged 4 to 11 years old, the prevalence amongst boys was 16.4% and in girls 14.6%, meanwhile amongst adolescents (years 12–18) males presented a prevalence rate of 2.1% and females of 6.9%. One interesting thing that the study revealed was that, in contrast to international rates, the 3:1 ratio of diagnosed boys over girls was not found (de la Barra et al., 2013). It is worth noting that in contrast with some of the official figures provided by the government previously discussed in this chapter, the study conducted by de la Barra uses the medical category of ADHD to replace the more descriptive categories of hyperkinetic, activity and attention disorders. By using the label of ADHD there is an attempt to bring these together providing a common origin by binding them together under one medical diagnosis.

²³ Paula Margozzini is a member of the Department of Public Health of Universidad Católica de Chile. She was the chief epidemiologist in charge of conducting the 2009–2010 National Health Survey

The study conducted by Chilean epidemiologists Flora de la Barra and her colleagues (2013) is interesting inasmuch as their findings help to orientate further inquiries related to the current state of ADHD in Chile today, both also because the study reveals some of the particularities of the Chilean situation, for instance, the alarmingly high prevalence of the disorder when compared to worldwide estimates obtained by global studies of ADHD (Polanczyk et al., 2007). In that sense, the study conducted by de la Barra demands further reflection upon the subject to clarify the reasons behind these results. Hopefully, my own research can contribute to this effort, encouraging more similar projects to come, aiming at dealing with social and medical problems by taking into consideration and highlighting the fact that the Chilean reality has specificities and particularities which are something to be studied and reflected upon, and not only taken for granted as 'one more case', similar to others presented in international studies and surveys. In a similar spirit, Margozzini's statement about future plans to develop a child-centred health survey also fosters expectations of an eventual body of research which can help to tackle the multiplicity of elements involved when dealing with mental health conditions in specific locations and with diverse communities (Bemme & D'souza, 2012). The results displayed by de la Barra and her colleagues allows us to reflect on the interesting and particular junction of different actors, stakeholders and locations occurring in Chile in relation to ADHD, to the extent that results and prevalence rates appear to contradict one of the most common trends about ADHD diagnosis worldwide: the fact of boys being much more frequently diagnosed than girls, as well as the total rate of prevalence.

Although not something on which I intend to focus my research, the gender component of ADHD found by de la Barra (2013) serves as a reminder of the fact that there is something particular about how the diagnosis is generated in Chile, therefore making it interesting to inquire what else might emerge as having been shaped in a way specific to the Chilean context. In the same spirit, questions about the particular ways in which stimulant medication interacts with children can be asked, with expectations that something unique might be revealed.

Additional concerns and calls for further research have been done by multiple agencies to consider the heterogeneity of elements involved in the Chilean composition of

ADHD. Already in 2000, the ‘Ministerio de Planificación y Cooperación (MIDEPLAN)’²⁴ published a document aimed to encourage and guide both public and private initiatives targeting children and adolescents during the period ranging from 2001 to 2010. In the document, the ‘hyperkinetic disorders’ are one of many named as ‘key problems’ for the Chilean State. The use of that term instead of ADHD seems to be guided by the idea that ‘hyperkinesia’ is a broader and more descriptive term, which can also be linked to other school-related difficulties composing the list of conditions that require special educational needs. Nevertheless, the emphasis of the Government on ‘hyperkinetic disorders’ has raised suspicions for some researchers involved with children’s mental health. They argue that the prevalence of the disorder — normally higher than international figures — along with the strong emphasis used by the ‘Ministerio de Salud’ to tackle and prevent hyperkinetic disorders as soon as possible, reveals that the idea of detecting and treating the disorder is embedded in an attempt to turn children into well-adapted citizens suitable for the work market, and not a genuine clinical concern (Abarzúa & González, 2012). This critique, whether justified or not, has become more popular in the mass media over the last five years, and places in the limelight one central concern driving this account: is it possible to consider that the diagnosis operates and follows the same trajectories and rationale in Chile as it does in other locations worldwide?

Conclusions

The trajectories displayed through this chapter aim to reveal the heterogeneous positions and relations that several actors have played in the framing of ADHD in Chile. Amongst these, it is possible to visualise how particular institutional and political contexts — such as the Chilean educational system and its reforms — have had a notorious influence on how social actors are distributed and relate to the diagnosis, as well as how stimulant medication has become more extended while, paradoxically, becoming more resisted than ever before.

²⁴ Chilean Ministry of Planning and Cooperation.

The claims against ADHD, its high rates and the use of stimulant medication, appear to have become a sign of a wider discontent that goes beyond the diagnosis itself, targeting the educational model implemented in Chile since Pinochet's dictatorship. This reflects the demands raised by the students in the manifesto handed over to representatives of the 'Ministerio de Educacion' on May 4th, 2012, entitled 'Proposal for the education we want' amid the student demonstrations that configured the 'Chilean Educational Conflict', which started in 2011 and has continued until the present day. The series of student-led protests aimed to change the main elements of how education is being implemented and reflected upon in Chile, and among the requirements the 'Asamblea Coordinadora de Estudiantes Secundarios' (Coordinating Assembly for Secondary Students) or ACES has put on the table in order to be negotiated with the government, is a call to stop the use of methylphenidate and the over-diagnosis of ADHD. This organisation argues that the diagnosis reaches 40% in certain schools, an excessive level in the light of international evidence, and underlines the suggestion of an abuse of the diagnosis in Chile (ACES, 2012).

Rather than dismissing the so-called 'abuse of the diagnosis' in Chile, its examination seems more promising, since it reveals how a psychiatric diagnosis which aims to be 'global' is, at the same time, extremely local. This reflection is closely linked to what Santos (2001) claims, when arguing that in the conditions of the Western capitalist world system there is no genuine globalisation. There is no such a thing as a pure or simple replication of a mental category or disorder from one place to the other. In Santos' words,

What we call globalization is always the successful globalization of a given localism. In other words, there is no global condition for which we cannot find a local root, a specific cultural embeddedness. The second implication is that globalization entails localization, that is, localization is the globalization of the losers. In fact, we live in a world of localization, as much as we live in a world of globalization. (p. 189)

So there is not one ADHD, and there is not only one standardised and universal use of stimulant medication that can be tracked down in Western world. Mental categories and even pharmaceuticals have local trajectories (Jenkins, 2011) and particular modes of use and reinterpretations of the same (Geest et al., 1996). Taking this into

consideration, and thinking along with Santos' claims (2001), it is possible to argue that in this sense, globalisation is always a series of multiple processes and interactions, and therefore a struggle between the local becoming global (the winner) and the local being colonised and designated, named, by the winner (the loser). If one category is to be extrapolated to another location, it must lose its specificity, becoming somehow neutral, divesting itself of many of its own attributes in a process that Andrew Lakoff (2005) calls 'diagnostic liquidity'. Lakoff realizes that '[in order] to be transferable — liquid — an asset must lose its specificity and locality. Classificatory technologies work to simplify, stratify, and standardize such assets' (p. 21).

When reflecting upon ADHD on Chile, it is possible to witness how, by emphasising the local determinants of the diagnosis, a new scenario comes into play. Educational policies and an extremely strong neoliberal economy appear to be at the base of a constant and severe surveillance of children's actions and behaviours. This also entails the widespread use of methylphenidate, the easiest and quickest way to deal with the symptomatic manifestations of the disorder. As stressed above, the recognition of these socio-cultural determinants of ADHD in Chile do not intend to erase or diminish the role that biological factors might have in the shaping of the disorder, or in the potential benefits and uses that may accompany the consumption of stimulant medication by children. My intention has been to display every possible element that might play a role in the strikingly high rates of both diagnosis and medication consumption in Chile. In this sense, this chapter has been an attempt to elucidate the rationale behind those high rates using, in order to achieve this, different pieces of information and accounts given by different actors in the Chilean context. This entails looking both ways: to what is being said by medical experts and those 'in favour' of the diagnosis and the different ways to tackle the disorder, including the use of stimulant medication; but also to take into consideration those who lately have raised a strong opposition to this, employing elements of the medicalization thesis to do so. My standpoint in relation to this is simple enough: the high rates of consumption of stimulant medication, which normally result from high rates of diagnosis of ADHD in children, present me with the opportunity to explore not only the practical effects of the medication, but also how its consumption became so widespread in Chile, why it is being contested lately, and by what means.

As mentioned, my interest in this matter is reinforced since the aforementioned interactions and determinations between different actors and scenarios have become more problematic, and even contradictory at times. As stressed above, there seems to exist a relatively widespread agreement in relation to the fact that stimulant medication is supposed to be only part of the treatment, and hopefully to be used for a short period of time assisting other, more complex interventions. However, according to multiple reports (Becerra, 2013b; Educarchile, n.d; Rojas, 2010) this does not seem to be what happens, despite experiences such as the one narrated by Sebastian Claro (2011) which reveals how interdisciplinary approaches may prove useful not only to reduce the amount of consultations to health professionals — therefore de-congesting the health system — but also that ‘bio-psycho-social’ interventions can bring together educators, medical practitioners, psychologists and artists in order to produce different understandings and outcomes in relation to ADHD children. Additionally, stimulant medication has come to be viewed as mostly negative by the media and lay people, which seems to be related to the hype around medication that occurred during the past decades. This is something to reflect on because, despite the evidence that stimulant medication is helpful in most cases, there is robust opposition to its use in various settings now in Chile.

Finally, it is important to remark that just as happens with the disorder, the use of the medication relies on the ecological niche where it is being used. In that sense, the trajectories that I have intertwined in this chapter serve as an approach to understand how stimulant medication and ADHD have been pushed into Chilean society, while also providing some clues for understanding why it has become resisted lately. Nevertheless, what I have mentioned in this chapter only portrays half the picture. It refers only to top-down dynamics addressing how governmental policies have sketched a particular landscape where the diagnosis has managed to thrive in schools. But it says little about how schools incorporate and embody these dynamics, turning them into pedagogical and educational practices, and it says even less about how children engage with them. As I mentioned in Chapter 1, it is crucial to pay attention to the actors, and not merely to the macro-structures shaping the field. In that spirit, in the next chapter I will focus on the schools where I conducted my fieldwork, and how children engaged with the medication and with each other inside those schools,

making creative uses of the diagnosis and entangling with the medication in various ways.

Chapter 4

The ‘training of the soul’ and the possibility of recalcitrance: the social life of the medication in the schools Mount Sinai and Bethlehem

Location: getting to know East Side Santiago and the Chilean elites

Rules: the influence of Schoenstatt in the making-up of children in a neo-Catholic landscape

Documents: gold standard and official guidelines

Actors: it is not easy to be a child

Conclusion

In a ground-breaking article published over three decades ago, anthropologists Sjaak van der Geest & Susan Reynolds Whyte discussed the central role that medicines have for patients and medical practitioners. They strongly emphasised the urgency to pay attention to the uses and impacts of medication on people’s everyday lives as pharmaceutical drugs became widespread, being now available also in developing countries all over the world: ‘Why are medicines so attractive in so many different cultures?’ ‘What social and symbolic processes do they facilitate?’ (van der Geest & Whyte, 1989, p. 345), they ask themselves, while they also encourage readers worldwide to think about the appeal of medication in different contexts, and about the different processes through which they become embedded in a wide variety of different settings. As the article progresses, they come to conclude that the value of medicines is linked to the perception that they have an inherent power to heal. However, there is a gap between the view provided by medical practitioners, for whom the meaning of each pharmaceutical has to do with its biochemical properties, and the process by which lay people attribute meaning and efficacy to drugs. With this in mind, van der Geest and Whyte conclude that despite biomedical attempts to give a ‘fixed’ meaning to the medication, or to provide a pre-defined way of action, the meaning attached and expected out of the use of pharmaceuticals is something mostly produced in relation to certain experiences lived by the individuals, and in accordance with the conception of illness where the medication is being deployed. In their own

words, ‘the specific meanings of a drug, the ideas about how it should be used and its specific capacities and effects, are highly variable’ (p. 350).

The aforementioned variability — compounded by the interactions between context where the medication is being used, the expectations of the different actors involved about how the medication works, and the material elements present in the setting — is a powerful tool in my attempt to debunk the long-standing belief that medication has but one effect, always the same, despite geographical locations and sociomaterial elements animating the setting where the medication is being used. In what follows, my aims will be aligned with concerns expressed not only by the aforementioned authors, but also by other social theorists (Behrouzan, 2016; Bush et al., 1996; Ecks, 2013; Etkin, 1988; Martin, 2009) who, in different ways, have stressed the importance that sociomaterial elements have in the construction and perception of mental disorders — such as ADHD — and also in how expectations regarding the use of medication and its potential effects are framed in wider sociomaterial settings. I will do so by discussing how the diagnosis of ADHD can be linked to different impairments depending on where in Chile the child is attending school. Similarly, the idea of the efficacy of the medication also varies in relation to what is considered as desirable for different educational institutions. In particular, this chapter suggests that the consideration of ADHD in Mount Sinai and Bethlehem schools, which formed part of my study, does not fully respond to the textbook definition of ADHD provided by the most popular psychiatry manual used in Chile, the Diagnostic and Statistical Manual of Mental Disorders or DSM-V (American Psychiatric Association, American Psychiatric Association, & DSM-5 Task Force, 2013). Rather, the definition of ADHD in these schools mirrors the concerns of a section of the Chilean elite in relation to what personality traits need to be strengthened as part of the schooling process to secure the possibility for children to remain as part of the same elites.

As I explain in the second section of this chapter, Mount Sinai and Bethlehem schools are the preferred choice for a portion of the Chilean elite standing for traditional values and conservative beliefs drawn from Catholic sects’ strict conservative principles. In particular, these schools are aligned with one Catholic movement called Schoenstatt, a self-proclaimed movement of religious and moral renewal, which stands out from

other neo-Catholic movements because of a certain ‘openness and tolerance’ towards the current social world, which is linked to the history of the movement. Schoenstatt — and other similar Catholic spin-offs — have experienced growing popularity among the wealthiest families in Chile during the last decades, at least since the 1980s. Their rise in popularity goes together with the declining attractiveness of more ancestral Catholic movements — such as Jesuits or Ignatians — in upper-class families, as consequence of the role they played in during Pinochet’s dictatorship, when many priests belonging to traditional Catholic movements sided with advocates for human rights, fighting for social change, which clashed with the more conservative and traditional positions commonly defended by the upper-classes and Chilean elites, who supported the coup-d’état (Thumala Olave, 2010).

Following the coup-d’état, the Chilean Church split into two branches, one more socially committed, embracing a progressive view; and another with a strong and distinctive conservative position; the elites leaned more towards the latter group (Aguilar, 2011). Attempting to preserve their traditional lifestyle, elites developed a bond with conservative neo-Catholic movements, who fostered a more traditional form of Catholicism that better suited the elite’s interests (Thumala Olave, 2010). The less socially-committed neo-Catholic movements sided with the elites, who trusted these new Catholic movements to train and educate their character and self-control in order to build ‘moral strength and fortitude’ (Thumala, 2007, p. 188).

In accordance with the latter, Mount Sinai and Bethlehem schools enforce the practice of a series of dynamics aiming to guide children to fulfilling a social imaginary of moderation and social nicety, of generosity and benevolence, amongst other Catholic-funded moral principles. These practices — which make an idiosyncratic use of the diagnosis of ADHD and present a peculiar way to value the use of the pharmaceutical treatment — converge in the execution of a particular ‘training of the soul’. This expression — coined in the epigraph of one of the documents stating the institutional criteria and objectives to be achieved through the schooling process — illustrates the expectations of how the schooling process is supposed to take place. The idea of a ‘training of the soul’ reflects the ways in which children are addressed by the schools’ staff and faculty members, and the production of a series of standardised regulations

and principles according to which children are constantly evaluated, and made to face and evaluate themselves. This process of (self)training attempting to guide the child to become ‘the right kind of individual’ — according to these schools’ Catholic view of the world — emerges and is put into action in accordance with one specific document titled ‘proyecto educativo’ or ‘educational project’. This is a 20-page booklet containing the core identity features of the schools, and from which a whole array of practices, regulations, and material modification in the school are crafted.

The educational project is shared with staff and faculty members, parents and children, from the day they become part of this academic institution. It is also available for download on their website. But although most people in the school recognise their existence and importance, not everyone seems to have read it, according to interviews I held with adult members of these schools. However, this is no impediment for the educational project to fulfil its purpose, which is to make explicit the vision of the child and of the world that the school wants to accomplish as the result of the implementation of their academic practices. It also states the self-proclaimed mission the school plays in society, and the role they expect their former students to play in Chilean culture. In the case of these schools, the ‘educational project’ was deeply influenced by Catholic ideas about how to relate to each other, about ideas of uniqueness and originality, and about how to develop into a reasonable person in closeness to God.

The educational project gives instructions about how the ‘training of the soul’ of the child must take place so that he or she can grow in proximity to God. Such training aims to turn the child into a respectable individual, becoming the live embodiment of the neo-Catholic vision of the world trumpeted by Schoenstatt, the spiritual movement behind these schools. As mentioned, the educational project's influence does not rest upon the fact that people become convinced of these principles because they read about them. Children in the school live amidst these principles, as they become socialised through actions and daily practices. The educational project expresses itself in how teachers orientate children towards certain actions and achievements. It demonstrates its silent authority every time children attend mass or pray before the beginning of a class. For me, its power and influence became clearer with every time I

heard a staff or faculty member reply to a child ‘that it is not the way we do things here’, or when they told me ‘children in these schools have to learn that...’ which was normally followed by a Catholic moral principle. In these and other enunciations and daily activities that I will discuss below, it becomes possible to observe how the ethos propelled by the ‘educational project’ infiltrates through most actions and teachings that take place in the classroom.

But the constitution of the educational project does not only reflect a neo-Catholic inspiration. It also strongly reflects the aspirations of the traditional and conservative elite of the country. In accordance to this, elite schools such as those where the fieldwork was conducted present distinctive educational projects. Their interest distance itself from mere academic achievement — although elite schools tend to excel in this as well²⁵ — and seem to reside in the production of an individual with a distinctive character, one who is destined to remain part of the elite and therefore mirror their ways. As some have argued, schools attended by children of the Chilean economic and social elite play a decisive role in the intergenerational reproduction of the elite itself (Moya Díaz & Hernández Aracena, 2014). This means that more than just focusing on obtaining academic achievements, what is at stake here is a process of social and cultural attunement which is directed in accordance with what is stated in the ‘educational project’ each school has.

The central role played by the educational project is, therefore, two-fold. It contains the core foundational principles upon which the schools were created, principles taken from both the neo-Catholic vision provided by the Schoenstatt movement, and from a certain social sensitivity linked to the elites; but it also serves as a grid from which actions, plans and regulations can be measured in order to see how they fit in the schooling process. In that sense, the educational project becomes central to understanding how everyday interactions unfold on the school’s premises, and what social, cultural and academic features are to be reproduced in the everyday interactions held inside the school. It is in accordance with what is stated in the

²⁵ In 2016, the *Prueba de Selección Universitaria* or PSU test (university selection test) results revealed that, from the 100 ranked schools, 94 of them correspond to private schools. Ever more, 43 out of the 100 are schools located in the East Side of Santiago. As expected, the schools where this research was held also qualified among the top 100. Cfr El Mercurio, 2016

educational project that pedagogical and disciplinary practices will be crafted, executed, evaluated, and potentially amended. It is in relation to the 'educational project' that behaviours and actions are weighed, to later be ignored, praised or punished. As I argue in this chapter, it is in accordance with principles declared in the 'educational project' that a certain version of ADHD will come to life in these schools, inasmuch as expectations of how children should behave and explanations of what drives their actions will be judged in comparison with what is stated in this document. But not only what will be considered as ADHD will be affected by school policies and pedagogical practice developed following the educational project. The effects of stimulant medication are also judged in similar terms by faculty members and other professional staff. Their effects will be assessed, keeping in mind to what extent its use allows children to mirror what is expected of an individual according to the educational project.

However, it is important to recall that the educational project does not only appears as the result of the deep Catholic convictions shared by the traditional elite who set up these schools decades ago. It also reflects their social sensitivity and world perspective. In that sense, this key document that is the educational project is also imbued by a specific ethos, a precise way to put these Catholic principles of charity, benevolence, uniqueness and generosity into action. As I will argue below when analysing this and other school documents used to guide the development of children during the schooling process, the individual foreshadowed in the indications given by these documents seems to be more aligned with the philanthropic ideals and values of the wealthy classes of the XIX century as described by historians such as Jacques Donzelot (1997), than with the modern and popular forms of Catholicism in Chile, linked with social action and political activism for human rights and social equality. This becomes crucial, as the aforementioned ethos, and the practices it encourages, favours idiosyncratic ways of judging the efficacy of the medication and the presence of the disorder. So, in order to understand how a particular version of ADHD comes about in these schools, it becomes key to elucidate how values, belief and opinions from the traditional elite found their way to influencing the configuration of the educational project, and from there, to animate different pedagogical practices in the daily life of the educational institution. After all, schools are permeable institutions involved in

daily dynamic interactions with their social context which, in the case of Mount Sinai and Bethlehem, is one mostly composed of families sharing traditional and conservative views of the social world.

The schools described, their educational project, the households attending the schools, the neo-Catholic influences and the geographical whereabouts of the schools — located in a privileged enclave in one of Santiago's wealthiest boroughs — provide the sociomaterial context where my fieldwork took place. Their influence cannot be overlooked, as they play a significant role in shaping specific understandings of ADHD. The forms adopted by the diagnosis on these premises is the outcome of the influences played by all the actors mentioned above. Similarly, the uses and efficacy of the medication are also open to the scrutiny of these actors, since they are the ones deciding if they are making the 'right kind of impact' in children's lives. Following up van der Geest and Whyte's (1989) arguments that opened this chapter, contextual factors provided by the agents and contingencies listed above contour and become an integral part of how the disorder and the medication come to be in this setting. The diagnosis is not a neutral or aseptic category, nor is the medication an isolated materiality. Both become part of human lives and human affairs. Both determine (constrain and enable) paths of action, at the same time as they are reciprocally determined (their potential limited or modulated) by their surroundings. Using Alisse Waterston's (2014) idea, it is possible to witness that 'things' such as illnesses and medicines have a social life, inasmuch as they are situated in networks of social relations and dynamics that cannot be considered either as natural or inevitable, being commonly understood by people in terms of the ideas, beliefs, and meanings that individuals attach to them. In this case, I argue that ADHD and stimulant medication have their own social life in these schools. They follow trajectories which take them from individual to individual, from child to child, from child to adult, and so on. They become part of social dynamics, of schooling processes and pedagogical practices. They impact and transform other actors — human and non-human — while also being transformed as they are captured in networks of meanings and in peoples' expectations. They are praised and/or rejected for potentiality. They change things around them, and their effects and efficacy are examined in accordance with the highly idiosyncratic networks in which they become entangled.

In the case study of Mount Sinai and Bethlehem, the particularities animating their idiosyncratic understanding of ADHD and of stimulant medication use can be traced back to the influential role played by their educational project, but also to the other factors listed previously. Without taking them into consideration, it becomes impossible to elucidate why certain versions of ADHD can emerge at these schools, while others have no place. Following Annemarie Mol's (2002) reflections in relation to the different meanings and circumstances prompting the emergence of different shapes of atherosclerosis in medical clinics, I also find it productive to reflect about the resulting expectation in relation to medication's effects that come out of the multiple interactions between the many human and non-human actors that can be found in the classroom, and in exploring the resulting nature of ADHD arising from these entanglements.

Only when considering all actors does it become possible to discover what exactly are the expected outcomes of the encounter of child and medication. Likewise, only by following the interactions of different factors — ideals, beliefs and aspirations influenced by the social sensitivities of the elite and of the neo-Catholic movement sponsoring this educational institution — expressed in the educational project can we elucidate how these schools aim to engage with the medicated child, and how they evaluate the different paths a medicated child can follow. After all, the successful or failed entanglement of children and medication is strongly dependent on the sociomaterial context where this merging takes place. Context provides the tools and techniques to assess the results of this encounter, and children enact the effects of the medication in schools that have specific expectations about how their social and academic development should unfold, expectations built upon the particularities given by the religious background, their social status and their spatial location. These are elements which influenced the very making of the educational project now being implemented to evaluate children, and to guide pedagogic strategies.

Although it is a fascinating and relevant topic of research, closely linked to some of the questions animating this thesis, I do not aim to provide an elaborated explanation of how elite schools came into existence in Chile, nor do I attempt to examine thoroughly the multiple mechanisms used by the elites to retain their social and economic status.

My research here differs from analyses such as those elaborated by Pierre Bourdieu and others in that tradition (Bourdieu, 2010; Bourdieu & Passeron, 1964), mostly because — when referring to the elites — my goal is more descriptive in nature, rather than analytical. Given that my main concern in this project related to how stimulant medication finds its way to the classrooms and with what consequences, I refer to the elites mostly considering that the schools I attended are but two of the exclusive group of schools attended by them. Therefore, the sociomaterial elements found in these schools affecting how the medication unfolds is influenced by their social views and sensitivities, which become translated into the schools not only in terms of processes of socialisation, but also in how they affect and modify the material landscape of the classroom itself, carrying along the potentiality to modify practices and actions. In that sense, belonging to neo-Catholic traditions closely linked to traditional high-income families, and being attended by these households, provides important elements to the ecological niche where the medication unfolds and where certain understandings of ADHD come into being, which could — and more probably would — vary if research similar to this one is conducted in other locations of Santiago. With that in mind, and for the sake of my argument, rather than addressing the topic of the constitution of the elites, I direct my efforts at providing a detailed description of the above-mentioned factors, rather than analysing how they came to be, or in wondering about how their attributes stabilised in time²⁶.

For that reason this chapter focuses on presenting the different elements composing and animating the specific understandings of childhood, medication and ADHD that could be encountered while conducting fieldwork in the educational establishment composed by the two schools — Mount Sinai, and Bethlehem — where this research took place. I argue that, to understand how medication works in the classrooms, it becomes also necessary to geographically locate the interactions taking place within these schools' premises. After all, their spatial location in the city also speaks about socio-economic status, the Chilean elite and their religious heritage, and about mindsets regarding the raising of children, about how discipline and learning take

²⁶ For a Bourdieuan analysis of the Chilean elites, see Joignant & Guell (eds.) *Notables, tecnócratas y mandarines. Elementos de sociología de las elites en Chile*. Ediciones UDP, 2011

place, and the purpose of attending school at all. These elements invest this educational institution with a specific history, and a particular psychological grammar (Behrouzan, 2016) for giving an account of children, their actions and behaviours, while also influencing the emergence of institutional policies, the regulation of children's behaviours, and the pedagogical practices made to take care of them — whether they may present 'special needs'²⁷ or not.

To tackle how these different elements dynamically intermingle, I start by offering a description of the geographical enclave where schools Mount Sinai and Bethlehem are located, while also analysing the implications that such spatial positioning carries in terms of the social composition of the schools. As previously mentioned, it is difficult to understand how the effects of the medication are expected to unfold, what situations they are supposed to aid, and what conducts they are supposed to strengthen, without considering the social life of the medication inside the schools which, it seems reasonable to argue, is influenced by the schools' interest in developing and nourishing in students a personhood in close connections with the traditional and conservative ideals and expectations of the catholic elites. Geographical location matters greatly, since for decades it has been an indicator of social and economic status. In Chile, nothing speaks louder about your social status than the school you attended as a child, and private schools from East Side Santiago act as a trademark of distinction and class. But status is not the only thing that comes attached to being a child attending an elite school. Attending Mount Sinai and Bethlehem schools also entails the availability of a rich material and human infrastructure which also plays a role in the ways provided for the medication to work and to be effective. As I will argue in the first section of the chapter, to provide an accurate analysis about the uses and effects of the medication it becomes necessary to interrogate and understand the landscape where it is being deployed. Doing so opens a path to further advance knowledge about the multiple factors that meet in the school premises, nurturing the preferred personhood the schools intend to

²⁷ As mentioned in Chapter 2, ADHD became part of the list of learning disabilities proclaimed by the Government of Chile, which allows schools to secure special funding if they are educating children with such condition.

produce, while also determining the academic expectations which each child will have to face.

Second, I give an account of the importance that the influence of Schoenstatt has in the educational and pedagogical practices held inside the classrooms. Chilean sociologists interested in studying the elites have addressed the importance that neo-Catholic education has upon imprinting a particular set of moral values and identity traits that function as their identity trademark. In that sense, neo-Catholic schools such as Mount Sinai and Bethlehem aim at reproducing a certain vision of the world. They socialise an ethos linked to particular ways of understanding Catholic faith, one that attempts to foster specific manners for boys and girls to inhabit the world. As I will discuss, this ethos inhabits and is spread through these schools, not only giving shape to actions and practices, but also producing a peculiar material landscape where constant reminders of how children should live and behave becomes available, and where religious iconography is always on sight, acting as a silent judge of how children conduct themselves.

Then, I give a close examination of the educational project that unifies Mount Sinai and Bethlehem schools. As mentioned, the educational project is the core element bringing together school policies, pedagogical practices, modes of discipline and self-knowledge practices. But, above all, the educational project states the characteristics of the model individual to be produced out of these practices. It offers a gold standard, a template, which can be used by teachers to measure the progress of children. Also, it offers the child a perfect example of the child they should try to become, the description of an imaginary creature who harmoniously embodies all the virtues the schools try to elicit. But this task does not rely only on the 'educational project' — although it is, unquestionably, its core pillar. Other documents also play a significant role in this process. These include documents such as 'kind of man (sic) our schools aim to educate', which are also highly idiosyncratic of not only the upper class of Santiago, but to the specific public constituted by those following the teachings and principles of the Apostolic Movement of Schoenstatt, a by-product of Catholicism. Schoenstatt — the traditional religious movement behind these schools — defines codes of conducts and ways of being for those attending these schools. In this sense,

the educational project reflects the deep influence of the Movement of Schoenstatt, and families attending these schools also rank as a high priority in their lives to be true to their religious practice. This is a crucial element to consider, since the use of stimulant medication does not necessarily aim at producing academic excellence but rather at promoting identity traits and ways of being together.

Finally, I offer excerpts from my early days of fieldwork to illustrate how these dynamics and heterogeneous elements manage to fit together, configuring my first impressions in the schools. The ways by which guidelines, documents, social expectations and human actors come together, revealing themselves and becoming present in the daily experiences of the classroom present dissimilar articulations. As I have described in previous chapters, there is no one exclusive way in which children engage with the expectations contained in the schools' documents. Their capacity to think and act differently from adults is constantly put into motion, making it impossible to sustain any longer the sheer fantasy of the child as a complete docile body, a blank receptacle of the socialisation processes. This becomes crucial since it is amidst these articulations between children's agency, socialisation processes, guidelines, teachers, expectations and so on, that the medication will be put into action. Hence the relevance of describing and understanding how the everyday struggles between teachers and students take place, how teachers' expectations of children behaviour turn into practices, enabling and blocking potential paths to follow regarding discipline and pedagogy for teachers and children.

Location: getting to know East Side Santiago and the Chilean elites

Because of a series of factors that range from policies regarding the land market, economic globalisation, to cultural shifts during the last decades, Latin American metropolises have become highly segregated, unequal and stratified cities, and Santiago is no different in that sense (Sabatini & Brain, 2008). Attempting to build a particular kind of social identity, the elites — along with intervention from the government — have made use of spatial segregation in order to develop a distinctive identity from the rest of the population. As Chilean sociologist Francisco Sabatini suggests, since the 20th century it is possible to witness how a portion of the city has

been subject to intensive interventions so it can resemble a more 'developed world'. This portion of the city — whose spatial delimitations resemble a conical shape when viewed from above — has been progressively colonised by the elites, increasingly excluding from this area those groups which do not seem to fit in their social structure. In one of many articles about the topic, Sabatini and colleagues quote Benjamin Vicuña Mackenna — the promotor of the first urban transformation plan of Santiago — emphasising how he attempted to 'make a clear distinction between the “(...)educated capital of Chile”. “Santiago itself, the enlightened city, the affluent city, Christian” and the “outskirts”, “huge sewer of infection and vice, of crime and pest, a true meadow of death”’ (Sabatini et al., 2001). Although Vicuña Mackenna's description probably does not fit perfectly the development and the current state of the city — especially when referring to the outskirts — his words are useful in describing an ongoing trend in the city's population distribution that has lasted until our days: wealthy families and those holding influential social positions tend to live apart, in this conically-shaped sector of the capital that has become known as the *cono de alta renta*, or 'high-income cone'.



Image 1: Spatial delimitation of the different boroughs composing the city of Santiago. From the city centre (white) going to the upper-right side is ‘el cono de alta renta’ or high-income cone. Its conical shape encompasses the boroughs of Providencia, Nuñoa, La Reina, Las Condes, Vitacura and Lo Barnechea. Original image taken from www.wikimedia.org

Ranging from the city centre towards the upper east side of Santiago, the high-income cone encompasses a series of neighbourhoods that, since at least the beginning of the last century, have been occupied by the wealthiest families in Chile. Popularly known as ‘Santiago Oriente’ or East Side Santiago, this geographical delimitation is composed of 7 boroughs — La Reina, Las Condes, Providencia, Vitacura, Lo Barnechea, and Nuñoa — hosting most of the best private schooling options for the Chilean elites.

A shared spatial location in Santiago, common leisure areas inside and outside the city, and being schooled in the same or highly similar schools have been crucial strategies

used by the political, economic and social elites to keep a position of social power and privilege. These mechanisms have been extremely effective in allowing them to keep their status, while also being a powerful tool in preventing outsiders from gaining access to this social group. Households belonging to the elites tend to share a common social background, which is not exclusively given by their families of origin as it is also sustained by the fact that they attend the same schools, which grants them several opportunities to develop social interactions with others sharing a similar background. By being schooled together, these children have the opportunity become acquainted with each other from an early age. They can learn to distinguish who belongs to their social group, and who does not, thus creating 'a network of power' which they can turn to in the future (Espinoza, 2010). This has been a central mechanism for the elites to retain their social and economic positions despite potential differences in their views of the world in terms of politics, economy or social considerations. As Chilean sociologist Vicente Espinoza (2010) explains, different views about society are less relevant than sharing the same background which, in the long run, forms deeper bounds and loyalties than anything else.

Constant mutual interaction since early childhood — such as the one provided by being schooled together — is a central element in the composition of a hegemonic and homogeneous group. Also, this explains the difficulties for 'outsiders' to get into elite schools, and to feel comfortable inhabiting those spaces if they ever manage to get in, since they do not share these connections or mutual history with the rest of the group. As is stated by the report elaborated by the United Nations Development Program regarding power distribution in Chile (2014), Chilean elites exhibit a propensity to oligarchising, which tends to block the possibilities for social diversity to be expressed in the elites, since self-trajectories, capacities or skills seem to be insufficient to access these social groups, or to access a position of power and/or social influence. In other words, when it comes to becoming part of this privileged group, what holds more importance is not studies or wealth. These factors are eclipsed by the importance of belonging to the same social circuit. Individuals are only granted access to the elites by knowing the right persons, and nothing secures getting to know the right people better than being schooled together since early age. At least that is what University of Chicago's Seth Zimmerman concluded after conducting a study commissioned by the

US National Bureau of Economic Research (Zimmerman, 2016). His main conclusion was that leadership roles or top positions in the business sector were persistently reserved for former students of elite schools, who later were admitted to top universities. But it is not enough just to attend a prestigious university. What makes the difference is whether children attended an elite school. In Zimmerman's words, 'ties formed with peers from similar backgrounds at top schools drive much of the effect of elite admission on leadership attainment' (p. 2).

The importance and influence of elite educational institutions has been a matter of discussion for Chilean social scientists during the last decade. The emergence of this as a field of inquiry is not random, and it seems to be linked with a growing discontent related to inequality concerning economic distribution and opportunities in Chile. Lately, social scientists have started drawing attention to the role of the elite in the stabilisation and reproduction of the social world in an attempt to concentrate wealth, property and social connections (Moya Díaz & Hernández Aracena, 2014). The interest in how elites manage to sustain themselves over time guided the interest of social analysts to the role played by schools in such dynamics. Chilean social scientists interested in studying the local elites (Moya Díaz & Hernández Aracena, 2014) have come to conclude that elite schooling aims at accomplishing three important things. First, neo-catholic schools such as Mount Sinai and Bethlehem 'certify' their students by creating an invisible mechanism of recognition and distinction when facing individuals from outside the group. They create a certain sense of pride in belonging to this group, in being different from the rest. Second, the school socialises children so they develop a specific sensibility through the training of ethics, aesthetics and behavioural codes since early age. Finally, it provides exclusive social locations for its members to interact, and get to know each other, creating connections and opening the possibility of bonding, which is deemed of utmost importance since it is through this process of knowing each other that they will learn how to help each other to retain their social position.

For elite schools to keep operating smoothly, it is required for them to not question their position of social and economic privilege. One way to achieve that is recruiting students from a background with similar social and economic conditions. That is why

admission process are highly selective. To begin with, elite schools normally use an economic filter. In a country where the monthly average salary is around 500.000 Chilean Pesos according to the *Instituto Nacional de Estadística* (2017), a private elite school's monthly fees can easily surpass 400.000 Chilean Pesos per child, plus the enrolment fees²⁸. In the case of Mount Sinai and Bethlehem, incorporation fees for the year 2016 were around 2.500.000 Chilean Pesos per student, while monthly fees cost around 410.000 Chilean pesos. Therefore, family income becomes a central piece for understanding who can attend elite schools, and who does not. However, being part of the elite is not only about the money, but also about embodying certain moral attitudes, and sharing cultural and social backgrounds (Aguilar, 2011).

The contextual factors described are extremely relevant if one is to understand the uses of stimulant medication inside Mount Sinai and Bethlehem schools. As schools are a place of reproduction and transmission of social, ethical and aesthetic sensitivities, they grant the possibility to rationalise and lead the children's behaviours and actions, enabling the management of their capacities and attributes and allowing the emergence of certain kind of individualities (Rose, 1988). In the case of the schools where my fieldwork was conducted, this is achieved by the early implementation of what the schools refer to as the 'training of soul'. This way to deal with children on the schools' premises accentuates the making up of identities in accordance with the social imagination and moral attitudes shared by the elite previously described in this section. Their viewpoint of the world, deeply influenced by their connections to Schoenstatt — the neo-Catholic movement responsible for these schools — infiltrates the rearing practices taking place inside the classrooms, orientating how children and their behaviour are considered and guided.

The influence of Schoenstatt: the making-up of children in a neo-Catholic landscape

²⁸ From the top 10 schools ranked in the 2016 version of the PSU, 8 are in the East Side, and 5 of them have monthly fees of over 350.000 Chilean Pesos. For a ranking of the top schools regarding PSU scores during the last decade, their enrolment fees, and other characteristics such as religious adscriptions, see <http://www.quepasa.cl/articulo/actualidad/2016/03/ranking-de-colegios-2016.shtml/>

As I walk through the main gate and head towards the offices where I am meeting Pía, the *psicopedagoga* in charge of working with children aged 8 to 11 in these schools, I cannot help but notice the abundant religious icons decorating the front yard and the main façade of the schools. Next to the gate that leads from the front yard to where the classrooms are located, a statue of the Virgin Mary — la Mater, or ‘the mother’ as they frequently refer to her — stands tall, white as snow, overlooking the entrance. I pass through the main gates and head to second floor, where I wait for Pía to come pick me up. While I wait in the reception, teachers and administrative staff walk next to me in a hurry. I entertain myself looking at some leaflets that are available on a table next to where I am sitting, waiting for interested parties to pick them up. The leaflets promote different things, from advice on saving your marriage, to motivational phrases encouraging the reader to educate their children under God’s grace. In response to the national discussions being pushed by feminist movements in Chile in relation to legalising abortion under specific circumstances, I find several flyers stating that the Church does not support abortion under any circumstance, while others mention that all life is unique and sacred. After 10 minutes, Pía shows up, smiles and ask me to follow her to an office next by.



Image 2: The left wing of the front façade to the schools. In it, it is possible to observe banners with messages inviting children and their parent to join for family mass. The banner on the far left reflects the conservative stance that some parts of the Catholic Church have in relation to what was at the time one of the most radical social transformations in Chile in terms of social rights: the abortion law. The banner shows a humanised foetus accompanied by the words ‘save me, I want life’.

As I sit down, Pía officially welcomes me to Mount Sinai and Bethlehem. She is charismatic and easy-going, and we quickly engage in a conversation about the ethos of the schools, and of people working in them. ‘For us, the most important thing is the moral upbringing of children,’ she mentions while she graciously offers me a cup of coffee which I gratefully accept. ‘You see, there is nothing more valuable than the enjoyment of living a life in accordance with God. That inspires our actions, and the whole way in which we look at the world for how it matters. Take, for instance, the name of these schools. Their names come from important stories shared by God in the

Bible, and we want the Bible to be an inspiration for children.’ She seems extremely convinced of what she is saying. The way she talks makes me believe that she has seen this happen time after time during the years she has been working here. I decide to ask her how it works, how these moral principles they proclaim become something else, and translate to children’s daily lives. ‘It is mostly through social bonds. It becomes a way to live and engage with others. It is about connecting with others by always attempting to be respectful and generous, and to treat others as equals. Catholic children, children educated according to these principles, well, they cannot be indifferent to the world around them. Do you know the story of the transfiguration of Jesus?’ she asks me. I nod affirmatively, as I tell her if she can please remind me of the details, as I am curious to know why she mentions that episode of the Bible. ‘Here we believe that the upbringing of children is similar to that process. Through education, the child must go through a process of transformation, achieving his potential as he grows closer to God’. After that, we talk for another 20 minutes about the schools. The rest of the conversation was also filled with references inspired by the Catholic tradition. When talking about boys, Jesus constantly was presented as the role model, while when we talk about girls, the reference was the Virgin Mary.

The events previously described took place during my first official visit to the schools. They serve to illustrate how strongly the Catholic imagination is present in the daily dynamics that take place in Mount Sinai and Bethlehem. Its ubiquitous presence ranges from material objects in the playground — statues, crosses, paintings and pictures, phrases carved in the walls — to signs in blue and green inside the classrooms, aimed at reminding children the proper ways in which children should behave, or the sequence of actions that every they should accomplish at the beginning and ending of every class. A picture of the Virgin Mary is present in every female classroom, while another of Jesus holding the Sacred Heart acts as a guardian of those classrooms destined for male children.

The strong iconographic presence of Catholic reminders is distinctive of not just any religious school. There are two things that stand out, placing these schools in a different position to others. First, the constant appeal to the figure of the Virgin Mary, the *Mater*. Secondly, iconographic representation and constant quotations to Priest

Joseph Kentenich, the founder of the Schoenstatt movement. Schoenstatt was founded in 1914 in Germany by a local priest, Joseph Kentenich. As the story goes, God gave Father Kentenich a charism²⁹. In contrast to most previous founding fathers, Kentenich was not gifted by God with just one charism, but rather one involving many strands since God's mission to him was also multiple: to create a new kind of man, and a new kind of Christian community, one that can confront the current world and its challenges³⁰. To produce this new man — as is stated in the educational project of Mount Sinai and Bethlehem — Kentenich focused strongly on education, developing what the schools describe as a 'pedagogical anthropology founded in Christ'. In practice, this pedagogy is sustained under three premises: 1) a life in alliance with God; 2) living an apostolic life, and 3) respecting the originality of everyone. To achieve this, the schools must provide company while educating children. It is the role of educators to guide children as their spirits open and get in touch with reality, experiencing the chance to meet God during the process. As was reflected in Pía's words during our first encounter, it is the experience of opening to the world what grants the opportunity to meet and welcome God into our own lives.

Mount Sinai and Bethlehem schools share this moral foundation and view of the world which expresses itself in different curricular and pedagogical options. For instance, although both schools share the same premises and develop their duty in close connection, sharing staff and faculty members, the distribution of children in the classrooms copies the traditional ideal of family, and of male and female identities, offered by the Catholic church. This entails that although sharing a physical space and a common educational project, Mount Sinai (a school for boys), and Bethlehem (a school for girls) keep separated classrooms 'according to their [children] sex, in order to bolster the development of their own masculine or feminine identity, and so they can value the complementation of sexes, especially during adolescence' (Mount Sinai

²⁹ 'Charism' has a special connotation when used in the Catholic sense. For the Catholic church, God has given to some specific people — mostly to founding fathers of Catholic movements — charismata, that is, gifts to be used to serve the church, and to be shared with the community. For instance, Saint Benedict was given the charism of liturgy and work, and to Saint Francis, the charism of poverty. In each case, the charism later becomes a central characteristic of that Catholic order.

³⁰ A detailed description of this topic is available in the official website of the Chilean Schoenstatt movement, available in <http://www.mundoschoenstatt.cl>

and Bethlehem, 2016. p. 16). These kinds of options are the ones that appeal to the conservative section of the elites to this kind of schools, as they are aligned with their own sensitivities about the role of male and female in society. As Gabriela, a staff member told me while talking about the openness of these schools to incorporate families that can differ from the traditional Catholic family depicted in Schoenstatt imaginary — husband, wife, multiple children —, Mount Sinai and Bethlehem boast about their capacity to welcome people who are not so strongly identified with their values, however

‘in practice, to enrol your children here [in this educational institution], you must be married, and your marriage has to be accepted by the Church. You also must attend Mass, become active in pastoral activities, and you must be willing for your children to go through the same. So, in the end, yes, we do get people who are different, who have more liberal values... and we accept them. But we also know that they won’t last long here. They leave. We know that they are eventually going to leave because they are not like us, they don’t see life like us.’

Consistent with the regulation of identities that accompanies Schoenstatt’s view of female and male according to God’s plan, recent analyses of the way in which Chilean elite schools operate have revealed interesting facts about the role they play in the constitution of a specific kind of character, emerging from the schooling process. From the overlapping influences of Schoenstatt and elite sensitivities, these schools bring together a series of identity traits which are acquired by participating in different dynamics and socialisation processes inside the school, both which are unique to the elites, and therefore present in Mount Sinai and Bethlehem. As Chilean sociologist Sebastián Madrid (2016) mentions, there are some common characteristics repeating in the socialisation dynamics children experience in Chilean elite schools: mostly, they are raised in a social environment devoid of social diversity. Most of them have no connection at all with other social classes, except when it comes to do *acción social*, or social action. This is a kind of charity work, particularly common in Catholic schools since it shares the ethos of assistance of those in need that characterises the Chilean Catholic church. As Madrid mentions, in this kind of interaction the relation with others is never in symmetrical terms. It is always sustained under the assumption that those

in need are in a position of subordination which naturalises a dynamic of social dependence.

The strong emphasis provided by the Catholic church to this ethos of assistance permeates Mount Sinai and Bethlehem, influencing how connections to a broader social world are imagined and implemented. In accordance with this social sensitivity, children are raised to think about social actions as acts of charity which are aimed at helping disadvantaged people, but never really compromising their own privileged status. This link between neo-Catholic views of the world and the privileged situation that this grants the elites has been a matter of debate even within the Chilean Catholic church. The left-wing section of the Church has denounced time and time again the upbringing provided by their more conservative counterpart. For instance, the Chilean Jesuit priest Felipe Berrios³¹ — a national celebrity because of the significant role he played in championing for social justice — argued against the kind of personhood these schools attempted to achieve out of their socialisation processes. As was mentioned in a newspaper column echoing Berrios' opinions, what caused his indignation — and the indignation of the more socially involved section of the Church and of society — was precisely

that "poor privileged girl" that thanks to her training and because of the upbringing provided by her school, learned to complain — with an existential gloom, and until tears roll down her cheek — about a God that allows poverty. But, however, is blind to reflecting — actually, she is incapable of it — how she and her family manage to accumulate, to hoard (...) the 90% of the wealth of the country. That is why the complaining about the current model of education and training of elites becomes evident to all. (Retamal, 2013)

Despite the criticism to which they are exposed, schools like Mount Sinai and Bethlehem deeply embrace the ethos granted by their historical linkage to

³¹ Felipe Berrios is a famous Chilean Jesuit priest. He founded several NGOs aiming to give a better living to those in need. Probably his most well-known NGO is 'Techo para Chile' (A roof for Chile), which builds basic housing for homeless people. This NGO is now present in 19 countries worldwide. Berrios is also well-known because as columnist for one of Chile's most influential and conservative newspaper, *El Mercurio*, he wrote many articles against private education, especially against universities located in East Side Santiago which he accused of giving an education based on contents, but with no social commitment. This was controversial since many of these universities had a strong presence of people belonging to neo-Catholic movements.

Schoenstatt. From this arises a certain vision of the individual, about how they are supposed to mature and about their role in society. This identity is built upon distinctive traits which is given to the students by the schools. Chilean sociologist Maria Angélica Thumala (2011) argues regarding this process that

for the Catholic majority inside the elites, religion plays a central role in shaping the identity of its members and their preferences in relation to work, the education of their children, or the way in which economy should be driven. Differences in relation to these topics, and other subjects, is related to the exercise of different kinds of Catholicism (...) These differences run along with a characteristic feature which is praised transversally in the elite (...) that set them apart from the rest of society: the training of their character. As part of their Catholic upbringing, the training of the character is represented as an element that justifies the social status of the elite. (p. 202)

The training of the character becomes a way of creating a social boundary between Chile's economic and social elite and the rest of the population, particularly, since the exercise of religious virtues have become part of an aristocratic ideal sustained under the idea of a moral worth (M. A. Thumala Olave, 2012), which is put into motion since schooling. This way, it is possible to observe that since early childhood, schools inspired by neo-Catholic movements exercise a strong emphasis on self-control and self-discipline. The rationale behind emphasising such characteristics is linked to the underlying idea that being able to embrace and exercise self-control helps the individual in his search for achieving personal virtue and personal value. There is an inner value, as Thumala argues (2011), in thinking about conduct as guided by moral Catholic principles. This idea of the child as someone who is still 'in the making', or whose main attribute is the plasticity to acquire new capacities and to be guided in the process, but with no really significant actual capacities to do something else, has been one of the core elements criticised by the new childhood studies, mostly, because it tends to picture childhood and children as part of series of stages in which what really matters is the end result, this is, the adult (James & Prout, 1997; Prout & James, 1990; Uprichard, 2008). In the case of Mount Sinai and Bethlehem, analysis such as the one mentioned authored by Thumala highlights the importance given by neo-Catholic schools to mastering certain kinds of characteristics, not because they are intrigued about how this happens in practice, but rather because developing a sense of self-

control and self-discipline is something exhibited by adults who are former students of these schools. Although the process by which children are guided to acquire these identities is indeed relevant, as I will explain in detail in the next section, it is important to acknowledge that during fieldwork children proved to have a say while these dynamics were enacted, as I will extensively discuss later in this chapter.

In the following section, I examine how from the influence of Schoenstatt and the social and moral sensitivities of the elites arise a series of documents and guidelines providing the criteria and rules orientating the everyday actions and behaviors inside the school, with the 'educational project' — previously mentioned in the introduction of this chapter — the most salient of these documents. Their relevance lies in their influence and capacity to orientate the everyday practices taking place inside the school. They not only provide the rules by which children are daily judged and disciplined, but also, they state the individualities hold dear by these schools. They contain their ethos, hence provide the social and moral horizon that children should try to attain. These documents are the ones guiding and evaluating the children's 'training of the soul', as they summarise and operationalise the contextual factors that have been described during this section. In these schools, medication and ADHD can only exist in relation to these documents, as they provide the landscape where their social life unfolds.

Documents: Gold standard and official guidelines

As I have been arguing throughout this chapter, religious and elite sensitivities give shape to an array of documents and guidelines which hold special importance, as they regulate and dictate the norms and criteria by which children progress and developments are constantly being compared and evaluated. They provide the core elements that guide how children are to train their soul, and they also define and contour the field where medication will be deployed, its efficacy will be measured, and its utility put to the test. In any educational institution in Chile, the most important document is the 'educational project'. This document acts as the 'nautical chart' for the institution (Manzo & Westerhout, 2003), that is, it helps navigate the everyday dynamics of the educational establishment. It defines the central aspects that should

always be considered when thinking about the organic functioning of the school, therefore, all the members of the educational institution must be reflected in the document. The 'educational project' is commonly considered as a highly coherent document, reflecting the objectives the school imposes on itself as part of their teaching commitment, while also making clear what are the educational policies and practices they will implement to achieve its goals.

A central feature of the 'educational project' is its capacity to bring together and interconnect the stated mission and vision of the schools with the expectations of the different members belonging to the educational institution —staff and teachers, families and children. In other words, it allows the school to state what they are going to do, how they are going to do it, and why they think that what they are doing is the right thing to be done. The 'educational project' is intended to act as a compass for all members of the school, helping them to understand the ethos of the institution and the ways this ethos is expressed in daily practices. This last point is of particular significance. The 'educational project' allows children and teachers to anticipate the experiences and insights that they will acquire in situ, as they are unique to each establishment, and therefore can only be acquired by attending and spending time on them.

Unquestionably, the 'educational project' is the most significant of all the documents encompassing the everyday of individuals inside Mount Sinai and Bethlehem schools. However, there are other documents and guidelines that also play a significant role, as teachers constantly resort to them to plan their activities in the classroom, or to help them to deal with situations arising from everyday interactions. These other documents are 'El tipo de Hombre que nuestros Colegios quieren formar' (the Kind of Man our schools aim to train); 'Memoria Pedagógica' (Pedagogical Memoir); and 'Manual de Convivencia Escolar' (Guidelines for School Coexistence). These documents are crafted in accordance with principles stated in the 'educational project'. They are aimed at deepening understanding of different aspects of Mount Sinai and Bethlehem's vision of the educational process, or at translating this vision into practices by providing instructions, rules and criteria to plan everyday activities. They

described what things can be done in the school, what needs to be accomplished, and what is to be penalised.



Image 3: Next to the whiteboard that is present in every classroom it is possible to observe some banners and signals that act as reminders of how children's liberty must be trained. The top banner illustrates the sequence of events girls should follow every morning: Say hello to each other and to the teacher while standing behind their chair; take out the necessary items they are to use until the first break; close their backpacks and hang them on the back wall where they can cause no distractions; put on the apron and, finally, get ready to pray. The lower-right part shows a picture of the Virgin Mary with baby Jesus. On top, it is possible to read the message 'nothing without you, nothing without us', commonly used to remind girls that becoming a 'good individual' can only happen as a shared effort, aligned with the moral values represented by the Virgin Mary. Classroom's attended by boys exhibit a picture of Jesus instead of the Virgin Mary, as according to conservative Catholic principles, boys and girls are expected to fulfil different roles in life.

My interest in these documents lies precisely in what I described above, in how they are used when reflecting about children's behaviours, in the pivotal role they play when control must be exerted in the classroom, or in how they encompass ideas

related to how liberty should be trained, and the part education plays in this process. Explaining the role of these documents is central, as they translate expectations from the outer world inside the school. They introduce Schoenstatt's views about the world and society in the classroom, while also guiding the training of children in their journey to acquire the ethics and aesthetics they are expected to inherit. It is through the implementation of these documents and guidelines that a neo-Catholic psychological grammar will emerge, allowing the use of medication for specific purposes. After all, Mount Sinai and Bethlehem enacts a version of ADHD which is pervaded by sociomaterial elements, which allows medication to emerge as a practice to engage with behaviours and actions clashing with their moralising and socialising enterprise. From this perspective, practices in relation to the medication of the child become a central part of a wider array of pedagogical and educational practices which, in Mount Sinai and Bethlehem, are set to produce skills, abilities, images, feelings, norms and actions that are constantly being exposed in public, as they are built through social interactions, and are meant to be expressed and evaluated as they unfold in social relationships, as is possible to observe in the following excerpt:

Catalina, the English teacher in charge of teaching one of the boys' classes, comes to where I am standing while children are taking an evaluation test to determine how advanced their English level is. This is only the second time we met. The previous one was when Pía introduced me to her and explained to Catalina that part of my fieldwork entailed that I was going to spend time in the classroom when she was lecturing. When I first arrived this morning, Catalina warned me that this class was extremely difficult as they got easily distracted by almost anything. 'You can't have any idle moments with them. Once you lose them [their attention] is hard to get them back', she tells me. But our conversation gets interrupted as she walks away after realising that instead of answering the test, Andrés is reading Harry Potter. Catalina scolds him, guiding his attention to the test. Once the children finish, Catalina asks them to work in groups, so they can share their answers and learn from their mistakes. As children gather in groups the noise increases. Although they are supposed to be working, most groups discuss random things. But instead of being concerned about this, Catalina seems more interested in the fact that Andrés is, once again, silently reading by himself. She once again heads to where he is sitting, and pleasantly guides him to participate in the group

dynamic. Andrés behaviour seems to fit better with preconceptions of what teachers want out of students: he is perfectly quiet, sitting by himself. He does not disturb the class, or produce any kind of interruption. However, Catalina seems to worry about him. As the bell rings and the children walk outside to play during the break, Andrés takes extra time to stand up, so when he finally gets out of the chair he is alone in the classroom. Catalina encourages him to go and play with the others. Andrés smiles at us, says goodbye, and then runs out of the room. I cannot help but express my surprise to Catalina, to which she replies 'If he doesn't go play, or if he cannot work with the others, then something is wrong. I cannot talk for the rest [of the teachers], but I don't want a robot in my classroom. Children should be able to engage, they should want to engage [with other children]'

A couple of months later I was informed that Andrés was on stimulant medication. However, as Catalina fairly exemplifies, medication becomes part of a wider arrange of things. It is supposed to help children remain calm and focused during the class. But more important than that is the fact that — for the interests of these schools — medication cannot interfere with sociality. It can channel it, guide it, boost it or even articulate it in a different manner. But medication cannot dismiss sociality. Its relevance is not only expressed in the official documents socialised by Mount Sinai and Bethlehem but it is also embodied and enacted in daily practices. Practices inspired in the official documents of these schools aim to produce the appropriation of the personhood that Mount Sinai and Bethlehem promulgates through bonds of mutual interactions between children and adults. Social interactions become central in the performance and transmission of pedagogical practices since, as anthropologists Diana Milstein and Hector Mendes argue (Milstein & Mendes, 2017), they are the way in which values, ethics and aesthetics are transmitted. It is through social interactions that '(...) these "long-standing dispositions" become engraved'. As this happens on a daily basis, their efficacy is not dependent on children's capacity to intellectually make sense of these practices:

it is not their reflections nor their rationalizations which allow for subjects to immediately interpret [the knowledge and meanings attached to the practices] and act "accordingly". It is the subject/body who acts since it is in its body that these dispositions to actions and schemes are engraved. (p. 37)

In other words, the educational project and the other documents produce a constant process of 'training of the soul', whose powers do not rest in their capacity to intellectually charm or convince children, but rather in its capacity to infiltrate their everyday lives through activities and social interactions, tempering their soul.

However, how the soul is to be moulded is open to variations. According to how old children are, and to the level they are attending, the shaping of their soul is directed to achieve different goals in accordance to the schools' consideration of what are the most substantial attributes a child must develop. In relation to this, Mount Sinai and Bethlehem schools divide the process of moral and social attunement children must accomplish in different stages. Children aged 9 to 11 — like those participating in this research — are located in a stage called Ciclo de Habilidades y Destrezas (Stage of Skills and Abilities). In this stage, children are encouraged and guided to the developing of mainly two things: building the necessary reflexivity so they can get to know themselves, and in increasing their capacity of self-acceptance. To bolster these attributes, as is stated in the documents and official guidelines, the schools ask teachers to be able to transform the classroom into a social setting where bonds of care and friendship can be developed between children. Teachers are asked to embody authority in such a way that is not felt as authoritarian by students. They must be in gentle control, their role resembling more a tactician than a wrestler, as they are discouraged by the schools from imposing authority or to antagonising children too bluntly. The rationale underpinning this is linked to the idea that providing a less controlled environment allows children to discover who they really are. Once they figure that out, they can proceed to work on themselves while also accepting their uniqueness.

But uniqueness can only be discovered and embraced by children if the pedagogic practices allow for it to reveal itself. Less coercive control and providing more gentle guidance in daily actions are the trademark strategies implemented by schools Mount Sinai and Bethlehem to grant possible the emergence of one of the central features of Schoenstatt's vision of the individual: the distinctiveness of every human being. According to one of the documents mentioned earlier, *El tipo de Hombre que nuestros Colegios quieren formar*, each child has a spiritual interior which is neither a product

of his own making, nor the result of mere social interactions or socialisation. Spiritual life, or spiritual interiority, is a gift and a mystery given by God. This has interesting implications in how discipline and authority are enacted in the classroom, particularly considering that for their pedagogy, that personal spiritual nucleus makes everyone completely unique, making ultimately pointless any attempt to fully understand or manage others. As it is stated in the in the opening pages of *El tipo de Hombre que nuestros Colegios quieren formar*,

when facing any person and his mystery, initially it is only possible to show respect. God creates everyone with original features. We have been oriented always as educators by a noteworthy concern for children' uniqueness, for their talents and their own development. That is why we have chosen to promote their own rhythm, and their own capacity to decide and to do (...) Uniqueness holds great potentialities. Each child must develop the search for excellence. That is why we face two challenges. One is that each child manages to discover and develop the gifts given to him by God; while also we face the challenge of helping children to reach their plenitude in all fields of human existence. We consider that it is essential in a true education to wake up the child to the life of a certain intelligence, one that is aimed towards the search for objective truth and goodness in all fields of human knowledge. (Mount Sinai and Bethlehem, 1999. p. 2-3)

I find this idea about personhood particularly intriguing. While it is possible to observe how the model version of the child stated in the official documents of the schools configures everyday practices, giving rise to pedagogical strategies aimed at fulfilling Schoenstatt's core principles through the 'training of the soul', it also becomes clear that uniqueness cannot be shaped at random, nor be exercised freely. Something gets lost in the translation from the documents to the actual practices, and this has to do with the fact that, despite everything, schools operate as disciplinary institutions, regulating time, space and bodies aligned with certain principles, through the circulation and implementation of particular set of expert knowledges about the child (Donzelot, 1997; Foucault, 1980, 1982, 1991; Harwood, 2005; Milstein & Mendes, 2017; Rose, 1988, 1998).

The mechanisms by which this process is achieved has been extensively described by others before me, with Glenda Mac Naughton's book being a good example of this kind of analysis in schools (Naughton, 2005). That is why, what strikes me of my

fieldwork experience is something different. It is not how disciplinary institutions aim at producing certain kind of personhoods, but the personhoods that actually emerge from within the constraints imposed by the schools. In that sense, medication traverses a landscape where 'psy' discourses (Rose, 1985) and pedagogical practices intertwine under the command that children embrace liberty and uniqueness. They are pushed to express themselves through social interactions, since it is in the social bonds that the ethos of these schools must be displayed. But just as Nikolas Rose suggests, the way in which this takes place cannot be reduced to 'a simple hierarchy of domination and subordination' that flattens all analysis involving psychology and psychiatry to the familiar topics of power and social control (1998, p. x). In that sense, the use of medication does not necessarily imply an act of coercion, or an attempt to render a body docile. It can, and probably does in schools located elsewhere in Santiago, or in schools underpinned by other ethic and aesthetics codes. However, in Mount Sinai and Bethlehem, the medication fluctuates between the limitations given by the official documents and guidelines that embody their ethos. As mentioned, it has a social life which moulds its trajectories and uses, its efficacy and worth. The uses of stimulant medication in this location, as is reflected by school policies and pedagogical practices, is more aligned with a gentle nudging of children to follow certain paths and to embrace the expected personhood in the process, rather than repressing potential selves through strict disciplinary measures.

Intriguingly, the social life of the medication in these schools relies heavily on the particular experiences each teacher has had with the medication, whether in person, or through reports gathered during their personal and professional life. This is mostly motivated by the lack of explicit directions provided by those in charge of handling and developing the pedagogical plans in alliance with the headmaster of the schools, and other people in directive roles. No reference is given about what to expect out of the use of stimulant medication in the official documents. For its part, ADHD is not specifically addressed. Its particularities vanish by being incorporated into a more general category, namely, 'special education' or 'SE' as they were commonly referred to by teachers and staff members. Children being labeled as SE received different treatment from regular children, which can be expressed in more focalised attention by the teacher when giving instructions, being more directly encouraged to participate,

being given more time for taking a test, or a lower scale when being graded. How the SE was, in practice, implemented, was open to variations according to the suggestions agreed by external medical experts performing the diagnosis or being in charge of the treatment, and the experts in the UTP of the schools. Two relevant things must be stated about SE. First, being diagnosed with ADHD or being under medication might grant a child the SE status only if that is agreed between the members of the UTP, the teachers and the external specialist overseeing each specific case. Some children can be under treatment, but if the school is not notified about this, they cannot include such information in judgements they make about the child's actions and behaviours. Secondly, that being granted the SE status does not necessarily entail that special considerations are in order. As some children are considered to be perfectly functional — academically and socially — thanks to the treatments they are undergoing, the SE status is given to them as a reminder for teachers and staff members to monitor the child's progress in case something goes wrong, but it does not entail any extra actions towards the child.

As observed during my fieldwork, several difficulties arise from the above mentioned. While the rationale behind hiding the specific diagnoses in the broader category of SE is to avoid any kind of stigmatisation by teachers or other students — as Pía and other members of the UTP told me — the effacement of peculiarities and characteristics of the diagnosis tends to result in confusion amongst teachers, although they recognise the good will behind the implementation of such academic policy. But in practice, gathering together most traits of difference under the concept of SE makes it difficult for teachers to know exactly how to address each child. As Marisol, one of the language teachers, mentioned during an interview,

I would love if we could get some training to understand better the different pathologies a child can develop, and how to deal with that. Because that way our efforts could be better addressed at what are the real issues. I'm aware that sometimes parents are cautious about their children being diagnosed, and about people knowing about it. But we [teachers] are here to aid their children, and sometimes I think people forget that. When we get informed about a child being diagnosed with a disorder, usually we get a document stating that the child X now needs special handling. So, we get that document saying the name, and a recommendation of how to proceed. So, it says

something like ‘give him more time to answer the quiz’, or ‘make sure he/she understood the instructions’, or ‘he or she is expressing some anxiety, so be more kind and patient’. But they don’t tell us why, or how are we expected to put those instructions into practice. And I feel that we [teachers] could do much better if we have that little extra info that could guide our actions. Because otherwise, we are left to our own devices, and that’s hard.

One of the things Marisol addresses is of critical importance, as it was an idea shared amongst several teachers during my fieldwork. They see their work as more than just being a figure of authority, or an embodiment of human knowledge. They tend to define and live their role as being companions to children. It is out of their feeling of helplessness in embodying such position that medication is judged. In other words, fieldwork experience revealed that in these schools — an argument that I cannot extend to other schools, as they present alternative sociomaterial settings — stimulant medication was judged for its capacity to ‘help children’ in one way or another. If it was considered not to be helping, then the medication was considered out of place, useless and even counterproductive. Marisol talks about this by arguing the following:

Ritalin is used for enabling the child to learn (...) It is not that we think “ok, I only want medicated children in my classroom”. No, that’s not the idea at all. Because the idea is that they can and want to participate and talk during the class, otherwise it is actually quite boring. When you have children that are overmedicated, that’s not the idea also. The idea, I think, is that they become able to control themselves. Bottom line, that’s the whole purpose. To control themselves and pay a little attention, that’s the ideal for me. It is not to have them sitting still all the time, looking away, absent-minded [because of the medication]. The medicated child is one that is more in control, but never a zombie. At least I don’t think so. Unless they are way too overmedicated, but that has never happened to me. But it could happen. I know friends of mine that have run into children that are totally absent, gone. But you can tell right away, because you have seen them non-medicated. If you start working with a child without knowing him from before, one would probably think “wow, this kid is weird, there’s something off with him”, but maybe you wouldn’t know that it is because of being overmedicated.

As mentioned, the lack of official guidelines for dealing with medicated children in these schools, along with the masking of the diagnosis by adopting the SE category, makes it difficult for teachers to realise how to act and what to expect out of children

and out of the medication. Talking from their role as companion, and with the idea of the child's best interest, some teachers like Marisol open themselves to being surprised by positive effects of the medication in accordance with her own experiences working with medicated children. But others plainly reject its use, fearing that the aftermaths of the encounter between children and the pharmaceutical treatment could produce the dreaded zombified status. The medication, as is revealed in teachers account, is aimed at regaining control — not exclusively their control over the class, but mostly children's control over themselves.

Thinking about the medication as encouraged by something else than simply disciplining individuals has been a recent matter of discussion. As Orkideh Behrouzan acknowledges (2016), psychiatric subjectivities — those produced out of and in relation to psy knowledges and practices such as using stimulant medication — are not necessarily the effect of top-down processes of psychiatric colonisation. They can also provide a means of personal expression, linked with social validation of experiences or with personal endurance. Medication can be a 'transitional and transformative object' (p. 117), whose social life is interwoven between contextual factors and individual and collective trajectories. Although medication can be used by the schools as a replacement of more traditional disciplinary techniques, as a means of 'somatic regulation, in which neurobiological modulation reduces the likelihood of uncitizenly conduct' (Vrecko, 2009, p. 229), I suggest that there is more to medication than that.

In addition, ideals about freedom, education, pedagogy and children's behaviour become more nuanced when they become translated from the educational guidelines and official documents to the actual pedagogical practices taking place inside the classroom. Ideas about uniqueness and achieving goodness and enlightenment only by being orientated by teachers with no disciplinary measures exerted proves to be nothing more than, precisely, an ideal, which impacts and modifies traditional disciplinary techniques, but that is unable to completely dismiss them. Following the indications provided by these documents produces the effect of discouraging direct and coercive disciplinary measures, but teachers still feel the need to say and do things during class so they can feel in control of the classrooms. This became evident during my fieldwork, as I observed how these actions were put into motion. Laura, a maths

teacher, normally used strategies such as asking children to take a walk when they were being disruptive in the classroom. 'Go take a walk, and come back when you can behave as a child attending 5to básico', she told once to Gustavo, a child who could not remain silent, and who was constantly annoying children sitting next to him.

The sentence pronounced by Laura is a fair example of how children are supposed to manage their uniqueness and liberty. The teacher is not punishing the child. He is not getting a notation in the class log, or being expelled. By making him take a walk, he is gently pushed to become aware of what is expected of their behaviour, of how that interiority should express itself. Something similar happened during the Art class. Girls attending class with Gloria, an Art teacher, mentioned frequently that they got bored during the class. 'Sebastián, take a close look at what is going to happen during the class. Nobody is going to pay attention to what she says. And everyone is going to start drawing or painting whatever they feel like', Amalia tells me, a girl notorious for sleeping during class.

And just as she predicts, the class goes wild. Girls just do not seem to care about what the teacher says, while Gloria struggles to regain control of the class. To do so, she scolds them: 'I haven't allowed you to speak during the class', she tells to one girl. 'Silence', she tells to another immediately after shushing Amalia. 'You have to learn proper manners,' she tells Victoria for not staying silent while she gives instructions to the class. But instead of feeling overwhelmed, Gloria says out loud, 'Ok, I can see you are getting bored, that is why people are talking.' After that, she changes how she addresses the girls. Instead of lecturing them, she makes them actively participate, gently forcing them into giving their opinion about impressionist painters. Although most girls seem to connect to this change in the class's dynamic, the class is constantly interrupted by Candelaria, who is eager to participate. Candelaria gives her opinion constantly, even if doing so entails interrupting other girls when they are speaking. It seems like she cannot help it, as if she could not control a mysterious force driving her into taking active part in the class. Candelaria is witty, and knowledgeable. It is not that she is talking about something random, or that she is mistaken. It is just that she replies to everything that is being asked to the class, and does not give room for others to learn and participate, the teachers will explain later to me.

But despite the good evaluation that, overall, Candelaria obtains from her teachers, she can be annoying to teachers and classmates during the class because of the actions and behaviours stated above. But again, Gloria does not openly confront her. She is not sent out of the classroom, neither is she asked to stop participating. What Candelaria gets is an advice that is directed to her ability to manage herself. First, it is only a comment. 'Candelaria, get a grip of yourself', says Gloria. 'Hold your tongue, think about how your classmates also want to learn, and to participate'. Candelaria laughs, as she looks slightly embarrassed. When the next question is asked, she raise her hand, and starts mumbling words. She stretches her arm as high as she can. And when another girl is asked to reply the question, Candelaria makes a gesture of exasperation. Two more questions are asked, and Candelaria is not chosen to answer. But then Gloria looks at her, while saying 'Ok Candelaria. Now it is your turn. Let it go, unwind.' Candelaria rushes to reply. She does not only answer what was being asked, but also corrects and makes clarifications to some of the answers given by her classmates, and asks Gloria a couple of questions about the subject. While hearing this, Gloria smiles.

These stories illustrate how Mount Sinai and Bethlehem's fundamental principles such as the uniqueness of each child and the encouragement for teachers to avoid directly imposing discipline, becomes partially modified by the demands of everyday interactions in the classroom. As teachers are also constantly evaluated by their capacity to review a pre-defined quantity of academic contents, they struggle to balance both things, giving rise to hybrid techniques, which do not fit with traditional techniques of imposing discipline nor with the pedagogical approach described in the documents and guidelines. The 'training of the soul' for the achievement and embracing of each child's uniqueness works alongside notions of self-discipline and self-knowledge that children must learn to put into action. Rather than directly confronting children, teachers seem to confront children with themselves. They make them 'look inside' so they can control whatever is that is happening, and once in control, they are given room to express it in the classroom. Of course, not all cases work like this. There are times when children get expelled from the classroom, or they are asked to stay silent and sit still in a very straightforward fashion. However, one of the particularities of the pedagogical style of this kind of neo-Catholic school is the

building up of a character that can manage to control itself, while expecting that the others will do the same. Uniqueness can only be expressed in mild manners, or in a controlled way. As it is stated in the educational project, freedom is something that needs to be understood correctly before it can be exercised:

Our children must grow to be free men, capable of owning their own lives, to drive their own history, and to give themselves to others as an act of love (...)
Freedom must be educated. We have always understood “training of the spirit”³² as the education for the correct exercise of liberty, where the central role is given to educating magnanimity, to the greatness of the soul. (Mount Sinai and Bethlehem, 1999, pp. 3-4)

Such understanding of freedom seems to link together practices held inside the classroom with the ‘educational project’. As the *Manual de Convivencia Escolar* states, Mount Sinai and Bethlehem are deeply influenced by the importance granted by Father Kentenich to training individuals that are capable of making up their own minds. Individuals should be ‘(...) driven from within, and they should learn to guide themselves per their own consciousness’ (Mount Sinai and Bethlehem, 2015. p. 5). This idea is nicely summarised in the unreferenced epigraph quoting Joseph Kentenich in the *Manual de Convivencia Escolar*: ‘Liberty, as much as possible. Norms, only the minimum necessary. But, above all, the maximum training of the soul’ (p. 1).

This ‘training of the soul’ is encompassed by a sociomaterial context where pedagogical practices are put into motion. For the sake of the self-training of everyone in the classroom, Mount Sinai and Bethlehem try to achieve an environment in which each individual can become responsible for their own actions, and as it is illustrated by the notes taken from the fieldwork and shared above, teachers are instructed to provide a learning environment that can secure these accomplishments. This learning environment is expected to be filled with ‘respect, responsibility, humbleness, love for

³² Throughout the documents, the word mostly used to talk about the interiority of children and other individuals is ‘alma’ or ‘soul’. However, in some parts of the documents the word ‘espíritu’ or ‘spirit’ is used. Catholic tradition in the Spanish language usually talks about ‘alma’ when referring to that something that inhabits our bodies, and hence gives us our ‘humanity’; while the word ‘espíritu’ is mostly used to talk about one of God’s manifestations, the ‘espíritu santo’ or ‘holy ghost’.

the truth and for communal spirit, among other things' (Mount Sinai and Bethlehem, 2015. p. 5).

Guidelines and documents such as the educational project offer the foundations from which a certain kind of personhood is expected to arise. They contain the mindsets of those in charge of guiding the schooling process, acting as a moral compass for teachers and staff members to guide their pedagogical and educational practices. But they also grant a comparison point for children. They exhibit the 'gold standard', that is, the criteria by which children should guide their actions and temper their souls. Guidelines and documents state the pivotal points by which the introduction of the medication in the school setting will be judged, and therefore also provide the milestones encompassing the social life of the medication.

Actors: It is not easy to be a child

All the previously mentioned elements come together in the classroom setting. Guidelines and documents exert their influence in such premises. Criteria and standards about how children's development must occur will be put into action in the pedagogical practices taking place in the classrooms. The social expectations, the moral guidance, the fostering of sociability, everything mentioned so far in this chapter happens in this specific location, where the 'training of the soul' becomes an actual practice held daily in the interactions between children and teachers. However, although these elements orientate and to some extent determine children's daily lives as they reveal themselves subtly, yet frequently, in the pedagogical and educational practices taking place inside the classroom, it is important to acknowledge that children also play a relevant role in how these interactions unfold. They are central actors playing a commanding role in the development of their own personhood, which makes it of the utmost importance to understand how they engage with the contextual factors present in the classroom. After all, an ecological understanding of subjectification as the one I am proposing for understanding the dynamics inside the classroom requires paying attention to all vectors sustaining how they develop a certain kind of personhood. Contrary to classic studies of children in schools, who over-emphasise the importance of the normalisation and regulation processes used for,

allegedly, governing and sustaining certain subjectivities in a unidirectional manner (Armstrong, 1983), I find myself aligned with social scientists suggesting that attention needs to be paid to the whole ecology of vectors involved, as ‘an ecological understanding of subjectification implies not a denunciation of the one vector that we think matters (authority) but an attention to what may matter to the becoming of subjects and, by the same token, to how subjects come to matter in that process’ (Savransky, 2014, p. 104). Following Savransky’s argument, by excluding the complexity that comes along with considering the full array of vectors involved in the making of subjectivities, we end up with a ‘purified, linear and direct vector of power’ and our understanding of subjectivity becomes flattened, as the ‘direct effect of a technological operation that encounters no obstacles in its way, an ideal technology of subjectification that never fails to engender its desired effects’ (p. 103).

Children in the classroom constantly face constraints, limitations designed and elaborated to not only stop them from developing in some orientations, but also to gently point them towards those the educational institution think are the right ones, pathways leading to become the embodiment of Mount Sinai and Bethlehem’s model version of a child. That is, a child whose rearing brings together the educational and moral expectations of the schools, and the sensitivities of the elite, a child who manages to be unique, but whose uniqueness is obtained by mastering certain personal characteristics, taming some personality traits, and learning to make the most out of being free.

Balancing all these vectors — as Savransky calls them — is not an easy task. More interestingly, at times it is not necessarily something wanted by children. They can engage with the expectations and with the educational and pedagogical practices while, nevertheless, having their own view of the situation. They can feel overwhelmed by the demands that are being placed onto them, or they can make use of the situation they are in to accomplish their own goals. For instance, children reported during interviews that being a child under the demands imposed by the schools was frustrating at times, since achieving what was expected of them in terms of sociability and academic performance is just not as easy as it sounds on the paper, as it is expressed in the guidelines and documents. In their view, adults — staff members,

teachers, psychologists — tend to oversimplify the difficulties of engaging with the daily practices taking place in the classroom, aimed at sculpting their soul in the right direction. Rosario, a 10-year-old girl reflects upon this by arguing

Making friends?... it depends. It is not always easy. For instance, there is a girl in our class who is always alone. Her name is Lourdes, did you meet her?... And it's like... like... when you ask her if she wants to go play, she is always reading, and sometimes she says no, and other times she says yes. But then, she says [complains] she doesn't have any friends. And it's true, she doesn't have a best friend (...) and one day, the teacher asked, "who wants to play with Lourdes?", but she asked that because she [the teacher] is lovely and caring, not because she was hinting Lourdes was lonely. So then, everyone raised their hands... but, in practice nobody actually hung out with her.

Rosario continues the story, recalling how, 3 years ago, she went through a similar experience. The girl that was supposed to be her best friend suddenly decided not to be anymore, just because she started hanging out with another girl. The other girl present during the interview, Javiera, adds the following to the conversation: 'our lives...it is not easy being a child sometimes. And I don't understand why, but some adults just don't get it. My grandpa understands me... and my aunt. But not my parents. It is a little weird, isn't it?'

Commonly, the experiences and difficulties narrated by children are quickly dismissed by analyses that over-emphasise just one vector to the detriment of more complex and ecological forms of analysis. This way, experiences such as those shared by Javiera and Rosario are normally ignored under the argument that what really matters is to understand how, sooner or later, the processes of normalisation and socialisation will occur. It is taken for granted that the school will manage to imprint the child's soul with the characteristics that will allow him or her to grow as close as possible to that model version of child extensively described in the official documents and guidelines. However, if instead of taking these experiences as something that quickly will be crushed or overwritten by the educational and pedagogical practices — with the help of other elements, such as the medication — we carefully listen to them, a different conclusion may arise. Because although it is true that the school might attempt, time after time, to guide the upbringing of the child in the directions pointed out by the official documents, it is also possible for children to put this effort to the test. Children

can prove to be 'recalcitrant' (Despret, 2008; Ferreira, 2015; Latour, 2007, 2013; Savransky, 2014; Stengers, 2010). This is, they can refuse to complete what is being demanded of them, they can reject or problematise what is trying to be imposed upon them, and they can certainly come up with new observations, points of views, and goals to be achieved. Recalcitrance both enacts a form of resistance, while at the same time affirms the relational engagement with the vector that is being resisted. In other words, the recalcitrance of children 'forces the vectors that configure that relation to change, to become other, by putting the questions posed by the respective authority to the test' (Savransky, 2014, p. 106).

By moving away from theories that only reflect on the schooling process as an apparatus aimed strictly at producing a specific personhood obtained through the training of the child, it becomes possible to allow the emergence of something else. By opening to the possibility that the desired effects contained in the documents might not be accomplished, or at least not fully as described in such documents, it becomes possible to acknowledge and listen to the transformations children undergo and achieve as the result of their engagement with the school's setting. Similarly to what Vinciane Despret (2008) mentions in relation to the experimental subjects in her own analysis, by opening up to being surprised by a different answer we may discover or learn something about their point of view, about what makes their world and how they engage with the materials which make their daily worlds. About how 'they engage with, accept and actively transform what becomes part of its [their] worlds' (Despret, 2008, p. 128). In line with this, it becomes possible to appreciate how Javiera and Rosario's voices reveal how, sometimes, pedagogical ideals fail as they become daily routines aimed at engaging with children in the classrooms. The model child presented in the 'educational project', that child that can look inside himself, master his urges, desires and conducts, becoming free and independent in the process, is not easily achieved and, at times, is not even what children want to achieve. As it has been mentioned during this chapter, in the case of Mount Sinai and Bethlehem schools, the training of the soul and the use of medication is not guided by academic performance.

At least it is not the main issue why children below the age of 14 are being medicated³³. The main cause for medication use was linked to difficulties experienced by children in collaborating in creating a respectful learning environment, or in being able to keep that particular kind of dynamic and mood in the classroom. But what adults consider a task to be easily achieved can, in practice, be difficult for children to manage. My conversation with Rosario and Javiera testifies to how things can get lost in translation. Their opinions serve as a reminder of how achievements that adults can dismiss because they consider them minor can, in practice, be experienced as significant challenges, difficult and critical to master, hence flagging important milestones to children's eyes.

Since it is not academic performance that is mostly spearheading the training of the soul and the use of the medication, children's recalcitrance seems to arise in relation to expectations about their sociality and the way they conduct themselves in social settings. For instance, in the case of Lourdes, she is under medication because she has problems focusing during the class. But on top of that, pedagogical strategies have been developed so she can overcome her extreme shyness. As Rosario points out '[Lourdes] was way worse before, like two years ago... back then she didn't talk to anyone'. The problem with Lourdes is not her performance — although this is far from ideal. According to her teacher's opinion, what is wrong with her is that she cannot seem to be able to engage with the class as she feels vulnerable and uncomfortable when speaking her mind. It is not only about her difficulties in focusing and paying attention. It is about the fact that on top of her impaired attention, she is shy. So, when her concentration flickers, she disengages from the class, and silently seeks refuge in her drawings without anyone noticing, as she remains quiet and still.

The development of particular kinds of interactions built upon the ideas of self-acceptance, self-knowledge and openness to the uniqueness of everyone is expected to be expressed in a classroom where everyone is not only encouraged and able to

³³ As an interview with a teacher revealed to me, most parents get on board with the idea of their children using medication during the last three year of schooling, because their grades become part of how they are going to get ranked when applying to universities. Grades from the last 4 years of schooling, along with the P.S.U exam, are the two elements used to apply to universities in Chile.

speak their minds, but also to listen and respect each other's opinion. To establish relationships with such characteristics is something not only rooted in the moral values that the schools aim to bolster in children's lives — values that are, of course, in deep communion with those expressed in Schoenstatt's interpretation of Catholicism. Becoming a person that can help to construct and keep an environment with the above-mentioned characteristics is also related to how children can relate to a higher power: God. However, even the invocation of a higher power could contribute to children becoming recalcitrant.

In a religion class taking place on April 17th, the class is noisier than usual. Although the teacher, Macarena, tries on several occasions to get the students to remain silent so she can start lecturing them, they just do not seem to care at all. Children are running and shouting, playing together. Macarena's face reflects how incredibly annoyed she is while watching everyone do as they please, as the usual pedagogical ways to engage with her students seem to fail. Then, she snaps. She grabs a big, heavy book, and hits her desk with it forcefully, making a loud, smacking sound. The students, automatically, look at her, surprised by the sound of the book. In that moment, taking advantage of the attention she is receiving, Macarena points at them with her finger, as she starts saying 'Enough is enough! One thing is to be disrespectful to your classmates, and not letting those that want to pay attention to do so. But you're also being disrespectful to me. And the worst thing is that you're being disrespectful to God. And that's the maximum lack of respect'. Her speech seems to deeply affect the children, as an absolute silence falls in the classroom. Macarena then starts talking about how God died for all of us, and how the least they could do is to remain quiet and silent as she explains to them His story. A little after, she asks children to join her in a prayer, so the class can start 'normally'. Nevertheless, only a few minutes later, part of the initial effect of Macarena's speech seems to have faded away, as if some of the girls in the classroom just were not interested enough in being part of the dynamic Macarena started. Two girls sitting in the back of the classroom are now cutting and pasting together pieces of their notebooks, building paper costumes they will later use to 'dress up' their erasers as different characters. Despite the teacher constantly addressing the importance of getting to know the story of the Passion of Christ, these two girls seem to be more interested in the activity they are performing.



Image 4: Erasers' clothes and disguises, created by girls during my time in the classroom. Designing and making these costumes was an activity frequently practised during the breaks, and even during class. What interested me about this was how this activity emerged constantly as a response to the lack of capacity by teachers to engage girls in daily activities in the classroom. In the pedagogical practices were not engaging enough, or if the teachers overexerted discipline, some girls commonly reacted to this by disengaging from the 'shared space' of the classroom, and folding back to their own private worlds where they would quietly play with their erasers.

The situation narrated above helps us to understand how the classroom is not only a place for normalisation and socialisation following top-down dynamics aiming at imposing just one potential way of becoming — only one accepted type of personhood — upon children. The classroom, and the schools for that matter, are situations of exchange. Places where different practices and interactions take place between a wide variety of actors. Classical approaches interested in the classroom setting have failed in realising the value behind these interactions, as their main concern has been to provide detailed analyses of how the one vector they are interested in — the school as an institution where power dynamics unfold — influences and shapes the others, as

if they did not resist or might have a say in this process. But by paying close attention to how these 'objects' upon which power is being exercised react and engage with this apparatus, it becomes self-evident that they are not just being moulded by external forces. They engage back according to what they see fit, they can also resist, or they even act back. In that sense, Mount Sinai and Bethlehem schools provide the ground for particular ways of (self)training of the soul for children attending these schools. But this acts not just as an imposition. Being situations of exchange, the 'training of the soul' is shared, engaged with, dismissed, rejected, and appropriated by children in different moments and in different ways. After all, understanding the schools as places where children can think, judge their own intentions, and can respond accordingly, allows for the understanding of schools as scenarios where subjectivities can be extended. Children can make use of the process of training their soul by partially or fully becoming what the others suggest to them, by accepting this proposal of subjectivity, acting in the manner in which others address them, 'actualizing and verifying this proposal, in the sense of rendering it true' (Despret, 2008, p. 135) as long as they become interested and engage in this process. But If educational and pedagogical practices fail to engage them, they will reveal their recalcitrance.

The latter becomes crucial as it renders it necessary to expand the scope of analysis. As the excerpts from the fieldwork reveal, despite how the 'training of the soul' attempts to engrave on children's identities the core elements of class and religion, children cannot be reduced to mere epiphenomena of the socialisation rationalities. As Savransky mentions, given that locations such as schools and classrooms are places of transformation, we need to 'fathom the entangled relationalities through which subjectivities come into being' (Savransky, 2014, p. 109). We should approach this matter in a non-reductive way, acknowledging how children and other actors play a role in achieving certain identities. As the 'training of the soul' takes place, and Schoenstatt and elite ideals attempt to attune the child so it can fit in what the 'educational project' presents as the model version of the child, actual children entangle with these practices and with other relevant actors in the classroom, acting upon themselves and upon others, which can lead them to challenge their aims, or to modify their practices.

Conclusion

Events such as the ones mentioned during this chapter become crucial to understanding how the medication and the idea of ADHD become deployed in the classrooms of the Mount Sinai and Bethlehem schools, as they provide the context where both the medication and the diagnosis will conduct their social life (Waterston, 2014). As I argued in this chapter, understanding of how medication works, proofs of its efficacy, and expectations surrounding its use, are all things that proved to be highly sensitive to the sociomaterial context where the medication was being deployed. Examinations such as the one I conducted in this chapter reveals how ADHD — the diagnosis commonly driven the use of the medication — and stimulant medication are tied to social imaginaries about better performance and academic adaptation. However, better performance and academic adaptation can mean different things and, in these schools, they are more closely connected to sociality than with obtaining better grades.

Scenes from the fieldwork such as the ones I shared during this chapter illustrate how, in these schools, children diagnosed with ADHD become more noticeable to adults not because their academic performance is weak, but rather because of how their behaviour clashes with the schools' expectations of how a child is supposed to conduct himself (or herself) in daily life, considering the moral attributes and intellectual capacities that God has granted each and every one of us. This becomes especially salient when it comes to social skills, which are highly valued by these schools because of their importance in the future life of these children as part of the Chilean elites.

Developing and establishing rich and varied social interactions, and being able to understand and play according to social codes of behaviour become central to understanding how discipline and pedagogical practices unfold in the classroom setting. Selfish behaviours such as not allowing other children to pay attention are more institutionally condemnable than obtaining poor grades, as these schools strongly emphasise the importance of children being able to accomplish a certain lifestyle closely linked to the capacity to conduct themselves in accordance to role model presented in the 'educational project'. The 'educational project' becomes of

central importance to understanding how pedagogical practices unfold daily, and how medication manages to find its way to the classrooms, as it provides the key elements constituting the 'psychological grammar' (Behrouzan, 2016) available in the schools to talk about and judge children's behaviours and actions. In line with this, the 'educational project' and the other official documents and guidelines shared and socialised in the schools act as mediators. They enable elites' sensitivities and Schoenstatt's ethos to become implemented, translating them into daily pedagogical and educational practices aiming at guiding the process by which children are expected to conduct their 'training of the soul'.

Children do not necessarily share the institutional interpretation of their actions, neither they share the schools' aims or scopes. They can be engaged by the pedagogical practices, becoming the embodiment of ideas shared by Schoenstatt and conservative elites. But they can also be recalcitrant. They can make use of the pedagogical and educational practices in consonance with other developments which are more cherished by them. They can refuse to become the model version of the child stated in the 'educational project', or they can only partially comply with its demands. They can surreptitiously or openly defy the official guidelines and documents, questioning their importance and the way they addresses them, contesting the schools' position as the only vector with authority upon how their lives are to be guided, as the schools do not have the only truth about their lives (Ferreira, Pereira, & Figueredo, 2014).

Considering how different vectors play their part in the everyday dynamics renders two things necessary. First, to acknowledge that pedagogical and educational practices play an influential role in the moulding of the specific identities that mirror and reproduce the influences that originally crafted the 'educational project' and other documents created to guide and animate the 'training of the soul'. Secondly, to realise that what actually happens in the classrooms cannot be reduced to the crafting of identities merely through the exercise of disciplinary measures aligned with top-down processes. A far more nuanced and richer process takes place, one in which pedagogical practices and disciplinary measures are put into motion, trying to engage children in developing certain identity traits, but where also children reveal different

techniques to cope with the attempts performed by teachers and others to engaged them in that dynamics. Human and non-human actors play an important role in how the choreography between children and others takes place. The sociomaterial context cannot be dismissed if one aims to understand how children come to inhabit the classrooms, and how medication unfolds in them. Especially because medication becomes an essential item used by the Mount Sinai and Bethlehem schools for children to develop their sociality, but it can also be used by children to become something else, to foster their recalcitrance.

As I will explore in the next chapter, children make different uses of the medication, as the mutual interactions between the child and the medication can also grant the capacity to act differently, but in ways that defy the school's expectations, or at least run in a different direction. In this sense, it is possible to observe that children are not merely the objects of a process of slow, yet constant, socialisation, aimed at training them as children of the elite. There is more to them than becoming good Catholics, or good students. Although they share an interest in using the medication for the purpose of developing social connections and interactions, they understand these as something valuable by themselves, and not because of the future benefits that they might entail. Children, in that sense, have their own personal worlds, which sometimes they manage to strengthen via the use of the medication.

Chapter 5

Between private worlds, shared spaces, agency and objectification: the deployment of stimulant medication in children's everyday lives and the rise of pharmaceutical entanglements

Children's agency inside the classroom

Thinking about agency as a shared property

Stimulant medication and its role inside the classroom

Agency as an outcome of assemblages: pharmaceutical entanglements

Looking back through practices: ontological choreographies in the classroom

Conclusions

In this chapter, I take a step forward from the discussions and reflections held in the previous chapter. I move from describing the different human and non-human actors involved in creating the sociomaterial and psychological landscape where the medication is deployed, to explore and analyse how the actual practices happening inside the classrooms of the Mount Sinai and Bethlehem schools allow us to achieve new understandings of how stimulant medication, children and other human and non-human actors come to interact and merge together in different, yet coordinated ways. This coming together — which enables the emergence of new characteristics by the medicated child — proves to be highly sensitive to the contextual and sociomaterial factors, as they play a significant role in how these entanglements are experienced and judged by children and their peers, and in how they are steered to achieve different goals. The use of stimulant medication can facilitate the pursuit of objectives aligned with what the schools explicitly declare in their educational project — implemented through the process referred to as the 'training of the soul'. However, the use of the medication can also be performed differently, bolstering children's recalcitrance. It is noteworthy to mention that, irrespectively of what are the goals to be achieved,

children exhibit a strong capacity to make use and make sense of the stimulant medication in manifolds and creative ways.

As I discuss in this chapter, the data I gathered while conducting fieldwork suggests that it can be misleading to consider children as simply passively constituted by 'external vectors', and equally misleading to view pedagogical and disciplinary practices as aimed only at achieving this, with medication therefore reduced to a supportive tool in this process. Such an approach risks depriving children of most of their capacities to act and make changes upon the world, which might lead to the wrong assumption that children are incapable of creating meaning or making sense out of the medication. I believe this approach to be problematic since the very way in which they design and ground their analyses disable all possibilities for children to surprise us (adults, researchers, teachers), as they dismiss the very possibility for children to display their agency. But if we pose questions about the uses and efficacy of stimulant medication differently, an alternative picture opens before our eyes. However, this requires us to be especially attentive both theoretically and methodologically about how we conduct our inquiries. After all, only new questions can unlock and reveal new realities in relation to this topic. Instead of repeating the same questions, creating an 'ecology of questions' appears to be a more fruitful option, an ecology of questions understood as the possibility to 'multiply the questions at stake and to evaluate the consequences that allowing for certain questions to dominate the debate may have upon a certain milieu of interrogation and intervention' (Savransky, 2014, p. 110). By the same token, expanding the questions of what happens in practice in the classrooms when stimulant medication and children engage with each other seems more interesting than just dismissing this interaction, reducing it to just another form by which discipline is implemented in the classroom.

As I discuss in this chapter, medications have the potential to induce various effects, some intentional, some unintended — commonly called side effects. In that sense, they do produce modifications in the body at a molecular level. However, these alterations and changes can work in connection with the agency of the child, they can antagonise each other, or they can produce something in between. This presents a

richer and more dynamic process than commonly described by most traditional approaches, namely, the medicalization thesis extensively described in Chapter 1.

As I explained in the first chapter, I believe that it is necessary to react with a healthy dose of scepticism in relation to analyses claiming that experiences of children worldwide are, for the most part, identical, as if sociomaterial and contextual elements could not alter the manifestations of both mental health disorders and medications, despite the fact that different accounts have proved the opposite (Etkin, 1988; Geest et al., 1996; Rojas Navarro et al., 2017; Singh, 2012). Besides, as mentioned in Chapter 4, it becomes increasingly relevant to pay attention to the entangled nature of the interactions between children and medication, which requires us to open our analysis to the possibility for children to have identities and capacities ranging beyond 'being vulnerable' (Christensen, 2000) or 'being incomplete' (James et al., 1998). After all, fieldwork experience showed that children's capacity of agency is richer than normally given credit for, a conclusion shared also by other studies conducted in several different settings (e.g. Bordonaro, 2012; Prout & James, 1990; Rojas Navarro & Rojas, 2015; Singh, 2013a). Their agency extends beyond defying rules and codes of conduct devised and imposed by adults, being linked with attempts to give meaning and integrate medications as part of their everyday lives.

This does not imply that psychostimulants are innocuous substances, nor that they should become the first line of treatment for ADHD. As with any medication — pharmaceutical or not — there are always risks and perils attached. But just as they can be hazardous, they can also provide relief if expectations about their efficacy are kept to reasonable standards, and ideas about stimulant medication as a 'silver bullet' are fended off (Macdonald & Loder, 2015; Sharpe, 2014). This is despite ideas suggesting the ineffectiveness of psychostimulants in treating a 'fictional' disorder such as ADHD (R. A. Barkley, 2002; Timimi et al., 2004)³⁴. It is not my intention to

³⁴ The argument about ADHD has a long history. The main discussion lies in whether ADHD is a valid mental health disorder or not. While experts who argue for the validity of the disorder normally claim that there are different kinds of evidence to support its existence, others claim that the lack of strong biological evidence reveals that ADHD is not a valid mental health disorder. From that point, other arguments have erupted concerning whether it is best to reflect upon ADHD as a biological or social issue, and what is the right way to address the

address that topic here. My interest lies in conducting a more nuanced analysis in accordance with my observations during my fieldwork. This way, I find it more useful to locate myself in line with scholars who although they have recognised perils in the use of medication, have also highlighted the potentialities of the same (Parens, 2013; Singh & Wessely, 2015) in accordance with the data provided by ethnographic work and genealogical approaches (Béhague & Lézé, 2015).

To explore how children's agency emerges in the classroom and how medication becomes part of this dynamic, I am adopting Clifford Geertz's notion of 'thick description' (2010). The advantage of using Geertz's idea of thick description lies in its provision of a theoretical framework which aims at more than simply describing what I observed during the time I spent inside the classroom. Developing a thick description entails providing a thorough overview of the structures and determinants involved in what is happening inside the school to understand how the events taking place in it are products of several forces which mutually determine each other, shaping how children experience and act in their everyday lives in relation to the introduction of stimulant medication.

Geertz's notion of thick description fits well with my intention to develop an ecology of question that allows us to interrogate the uses and effects of stimulant medication beyond traditional analyses and their tendency to overemphasise the influence of authority, as described in Chapter 4. Instead, thick descriptions help to highlight the dynamic interrelations established by the different actors in the sociomaterial context provided by the classroom. The dynamism and plasticity present in such a setting are central to understand how agency comes into play in the daily life of medicated children, configuring what has been referred to by social scientists as 'ontological choreographies' (Berg & Mol, 1998; Cussins, 1996; Thompson, 2005). By this, I refer to the ways by which different elements come together in a zone of compatibility, producing coordinated actions which are sustained by many ontologically heterogeneous actors. Providing a 'thick description' grants the possibility of unveiling

problem. A general overview of these discussions can be achieved by comparing the statements made by both parties: the original statement (Barkley, 2002) and the reply by critical scholars (Timimi et al., 2004).

the real impact that stimulant medication can have inside the classrooms, revealing the trajectories the medication follows. After all, psychostimulants do not appear in the classroom out of thin air but linked to stories, dynamics and practices. Furthermore, a thick description makes evident how stimulant medication's central role is always mediated by the child, and therefore is highly dependent on the different uses and understandings that children are capable of and willing to give to it. To provide this thick description, I will explore, describe, interpret and analyse the practices as they are performed by different actors involved in the classroom.

Thinking about how certain locations allow the emergence of situated agencies, Annemarie Mol (2002) argues that the capacity for agency is not something individuals own. Rather, it can be explained as the product of fragile assemblages, 'patchworks' — as she calls them — which bring together heterogeneous elements and determinants. This provocative idea is helpful to think about the involvement of each actor and the role they play in the practices related to the uses of stimulant medication in the classroom. It is through the coming together of different actors that a contextual capacity emerges, a kind of agency that cannot necessarily be exhibited elsewhere in the same fashion. It is a local entity, performed in a determined space and time. Therefore, as Law and Mol (1995) mention, in order to understand it, attention needs to be paid to the specific ways in which this entity — the agentic medicated child — becomes stitched together, while also attending to the threads used in the process. Mol's idea of 'patchwork' is closely linked — even seeming to overlap — with the previously described notion of 'ontological choreography'. However, as a metaphor it seems to lack the evocative power of dynamism and plasticity that the idea of 'ontological choreography' has, as this idea better describes the interactions, trajectories and exchanges that different elements have in the classroom, which acts as a scenario, a field of action where children make use of the medication in specific ways, where specific 'ontological choreographies' arise and are enacted.

This chapter will be organised as follows: first, I review some core ideas available in social sciences to reflect upon the notion of children as endowed with agency. To do so, I place the discussion of children's agency within a specific setting — the classroom — to underscore how active individuals who can make social and moral judgements,

and that are skilful enough to cope with authority in manifold ways. I find classrooms to be an interesting location to study children's agency because of the dynamics that take place there. In this context, children must simultaneously deal with adults and disciplinary practices, while they also attempt to preserve their own private worlds. This highly dynamic process of hiding and revealing their interests and views of the world, of engaging and disengaging with educational and pedagogical practices, gives room for the appearance of surreptitious ways of agency. I consider this to be a starting point to later understand how medication also gets involved in these dynamics. Medication, often seen by critical theorists as a device for normalisation, is also drawn into the dual dynamic enacted by children. On one side, it plays a shared role with teachers and other adults, but it is also included in how they frame their private worlds as children, and is given particular characteristics and attributes in this other arena.

Second, I discuss the idea of agency as a shared property, highly sensitive to the context where children and other actors meet. Whether they are medicated or not, it is only in relation to other actors and to the context provided by the classroom that children can perform this emergent capacity, making new decisions and actions for which they can now claim accountability. In that sense, agency sprouts out of the interactions being held by actors, and cannot be reduced to a property being owned by someone in particular. It is not something inherent to the medicated child, but emergent from the fragile and dynamic assemblages taking place in the classroom. Therefore, medicated children can learn to make use of these sprouts of agency arising from the entanglements they develop through the orchestrated interactions with other actors to move through their daily lives, surpassing the problematics that arise out of it.

The third section of this chapter exemplifies how agency is put into action by actors involved in the daily affairs taking place in the classroom. Taking data collected during my fieldwork experience, first I present an overall impression of how stimulant medication and children act and are perceived by others in the classroom. By doing this, I address how children construct and sustain their own private worlds, which can collide and merge together with the landscape proposed by adults and their understanding of the classroom — governed by the idea of the ‘training of the soul’,

discussed in Chapter 4. This process of accommodation and assimilation between both worlds is crucial to understand the nuanced trajectories that medication travels once it is introduced in the classroom, as it reveals the different possibilities by which it becomes part of fragile assemblages which allow new forms of acting together, in coordination, establishing novel choreographies in the classroom. In other words, it is only by understanding the general picture of the relations between children and adults in the classroom that it is possible to highlight the novelties taking place when the medication is introduced, and its production of new forms of choreographic dynamics between the different individuals in the classroom. For this reason, I explore the role of stimulant medication in the classroom only after discussing some of the basic principles underpinning the experience of the classroom from adults' and children's viewpoints.

After discussing the role of stimulant medication in relation to the experiences of teachers and medicated children — and the way in which the medication becomes part of the different practices in which they are immersed — I discuss the idea of pharmaceutical entanglements, that is, the different potential outcomes that may be obtained by the process of hybridisation of the child thanks to the use of stimulant medication. This is significant, as the trajectories, uses and effects of the medications cannot be pinpointed just as produced by a single person's capacities, nor as the mere chemical properties of the drug. As I discuss in this section, the medication has to be put into action by someone, and for something.

Finally, I refer to how, by considering the ways in which different actors become interlinked in the classroom, it becomes possible to see how each one of them determines each other while, at the same time, they become determined by other forces. These dynamics end up configuring coordinated actions, movements and counter-movements through rhythms and places designing a choreography that displays different versions and possibilities for the medication and for the medicated child. In order to understand this interconnectedness that is produced in the classroom between the different actors, I introduce the notion of ontological choreographies. My main purpose is to explore how introducing each of the actors previously described allows us to think about the classroom as something more than just a setting aimed at

normalising the child, where children are produced following other's wills and interests (Donzelot, 1997; Foucault, 1991). Children exhibit a capacity for agency, different from the kind normally expected from adults but no less relevant when thinking about the classroom (Wall, 2010). Re-thinking the classroom under the scope of children's agency enables the discovery of how medication plays different roles, and how it can be useful and/or detrimental, according to how the assemblages between the different actors in the classroom take place.

Children's agency in the classroom

The idea of children as capable of displaying a capacity of action in their surroundings and in relation to themselves is far from new. Children have been considered as individuals with particular competencies and capacities in some fields of social sciences at least since somewhere around the 1980s. In this sense, it is relevant to highlight the role played by the Sociology of Childhood. This area of inquiry was one of the first — if not the very first — which sought to reflect upon children not only as individuals provided with agency, but which also reflected about how to reconfigure the understanding of how social structures are open to the influence of children as agentic beings (Oswell, 2012).

The emphasis on children's agency has been so strongly addressed during the last two decades that, in some areas of social research, it is possible to observe the emergence of an agency-centred paradigm of childhood studies (Bordonaro, 2012) which, I claim, must be carefully evaluated. This is because it is not enough to just declare that children have agency, and start searching for evidence of such an attribute in different locations and contexts. Agency is not a universal value shared and displayed equally by everyone, and it is not a property to be found distributed equivalently among different individuals. Childhood studies apparently have been too eager to find examples of children's agency, which has led to sometimes forgetting, or to not taking fully into consideration, how the social, economic and historical determinants where such capacity of agency arises, are involved. But while the agency-centred analysis tends to dismiss these determinants, the answer does not seem to be located in adult-centred approaches which, as Lorenzo Bordonaro suggests, are used to downplay

‘children’s autonomy, reflexivity, agency and capacity of resistance, dealing with them as mere victims’ (p. 414).

This is central when reflecting upon my fieldwork. The capacity of agency that I observed during my time in the classroom is not an unimpeded one. It is not a pristine capacity which stems from the child unrestrictedly from the context. In this sense, it is important to consider what kinds of agency these children have, and under what circumstances it can emerge and express itself. In this context, it is key to recognise how a central duality comes into play. On the one hand, the school manifestly declares itself as constantly trying to underscore each child’s originality and authenticity, as extensively described in Chapter 4. For the same reason, some teachers consider stimulant medication as a threat to the accomplishment of this goal. They fear that it might wreak havoc in children’s abilities to bring out their uniqueness, and master it. Therefore, the use of stimulant medication is carefully weighed in every individual case since its use might compromise one of the core pillars stated in the ‘educational project’. Jaime, one of the school educational psychologists, mentioned during an interview that

[the school] has a different approach to the use of [stimulant] medication because, regardless if we can’t totally implement our educational project... everyone, and especially the teachers, everyone is invited to have a special consideration in relation to every child’s originality. I mean, we [the school’s staff members] should be challenged constantly with the idea that we must not standardise them [the students].

But, on the other hand, and despite the schools’ declared interest in recognising the originality and individuality of each child, it is mandatory that every child has to deal with the structures and different forms of intervention adults impose on their lives for the sake of obtaining ‘positive’ goals (Wyness, 1999). This translates into different interventions which are expressed in a variety of modes by which discipline is imposed, and restrictions on the expressions a child can demonstrate in the class are enacted. This reveals how certain ways of thinking about how children should be ‘civilised’ are in order, so ‘healthy behaviors’ — as Andrew Lakoff calls them — can be embodied (2000). This is borne out by a long tradition of ethnographers focused on educational institutions, who have argued that there are certain principles that govern schools in

Latin America — and probably also in most western societies — which relates to certain rules organising the ‘social order’ of the school. For instance, schools give the highest importance to organising spaces, and children must be respectful of that. As Diana Milstein mentions, in schools ‘there is a place for everything, and everything has to be in the right place’ (p. 123). No matter the uniqueness of the child, this will be an obstacle they must learn to master.

The duality between imprinting these principles and the search for each child’s uniqueness becomes central when translated to the classroom, and when reflecting about the role each individual plays in such setting. After all, the classroom is a privileged location to witness how children’s agentic capacity becomes entangled with several bodies of knowledge and experts that, to different extents, mediate and modulate their capacity of agency. When I claim that children have a capacity for agency, it is important to bear in mind that this capacity expresses itself in the ways in which children can deal with their context while engaging with others who are also involved in it. Their agency is displayed in their ability to traverse through the demands imposed by the educational setting, while managing to accomplish things that are meaningful to them, giving sense to some of the actions and events in the classroom according to their own expectations rather than simply accomplishing what was expected of them, or replicating successfully the imaginary child who embodies all the virtues proclaimed by the school that can be found in the pages of the ‘educational project’. Under these circumstances, agency does not mean unrestricted freedom. It means giving personal meaning to these situations, it implies being able to bend — to different extents — these daily events in ways in which children feels suits better their own purposes, while influencing those around them, making it possible to sustain this course of action. It is an idea of agency that departs from the one normally used by childhood studies, and that grows closer to the one proposed by Charis Thompson (Cussins 1996), who underscores how individuals and their agency must always be considered in relation to their environment, since this plays a crucial role in how agency emerges: ‘[the environment] changes how many descriptions we fall under, of how many parts we are built, and how integrated we are or need to be’ (p. 169). The setting, in its interactions with the individual, allows for ontological variations to be

accomplished. Therefore, the child's agency must be considered in relation to the interactions in which the child is immersed.

I emphasise the latter since it appears to be an over expectation among scholars studying children's agency in relation to the extent in which this capacity can take place. As some have argued (Bordonaro, 2012; Lancy, 2012), the child agency movement has reduced the search for children's agency either to expressions of unrestricted freedom, or to their capacity to make adults notice and respond to their needs and wishes. It has become, according to Lancy (2012), a deeply ethnocentric and hegemonic movement, an expansion of a western, upper-middle or bourgeois ideal of childhood which is translated to other locations without recognising the cultural differences between different kinds of childhoods worldwide. Lancy's critique of the 'child's agency paradigm' emphasises how these accounts of children's agency tend to forget how constraints emerging from the social, political and economic determinants frame, on a larger scale, the issue of agency. Because of this, I do not regard agency as becoming more noticeable to adults, or being able to act freely. I suggest that agency is something that happens between constraints imposed by the context, and that is closer to personal meaning than to external recognition.

It is amidst the scenario of multiple vectors clashing, in constant accommodation and mutual reshaping that stimulant medication comes into play. Considering that the classroom itself frames the possibilities in which children's agency can be displayed, the introduction of psychostimulants has been a matter of debate and, to some, stark opposition, since it is feared that it might add further obstacles for children to express their sense of agency, a fear that echoes that expressed by Jaime, the school psychologist mentioned above. As discussed in previous chapters, the rise in children being diagnosed with behavioural disorders such as ADHD has raised concern in lay people and experts about the medicalisation of childhood (A. Lakoff, 2000; Singh & Wessely, 2015)³⁵. For these critics, medicalising children blurs the social, historical, political and economic determinants which have shaped the educational system in the

³⁵ Andrew Lakoff (2000) provides an interesting discussion of the relations between behavioural disorders in children, and the attempts to 'civilise' such behaviours. A similar attempt, but this time considering the specificities of the Chilean context, is provided by Sebastián Rojas Navarro and colleagues (2017).

way we know it today. The true problem, or so they argue, it is not children's behaviour but our expectation of how they should behave. These expectations are sustained in an understanding of personal success and everyday life which is deeply influenced by economic factors. When failing to achieve the process of civilisation in the way adults want it to happen, medication supposedly comes into play as a way of containment. Medication, in this sense, has been accused of being a way of 'taming' children in order to decrease their capacity for free action, since these actions are considered troublesome by the educational system. As it is possible to observe, the problem of stimulant medication, of containment, and of mischievous, troublesome or regular actions in the classroom, can be framed as a problem of agency. It is an issue of how agency can be displayed, when, where, and under what circumstances.

Because of the above mentioned I suggest that the classroom is a key context to understand how the agency of children emerges as the result of a series of interactions. Despite some alarming reports about how stimulant medication may numb children's capacity for action, I claim that psychostimulants play a key role in understanding how medicated children live their everyday lives, but this does not necessarily entail giving up or fully compromising their sense of agency.

The contingencies involved in this process are multiple, as I got to observe during my fieldwork. The classroom provides a shared ground where diverse knowledge targets children in order to produce a predefined ideal, where different mechanisms are put into action in order for each child to be 'healthy', to 'succeed' and be able to 'achieve', where certain kinds of social skills are stimulated, while others are discouraged (Ariès, 1975; Foucault, 1991; Harwood, 2005). However, analysis centred on the 'making-up' (Hacking, 2007) of children by different fields of expertise, often elide that the school settings are composed by individuals who can, in different degrees and to some extent, engage and modify the functioning of their context. Individuals who can become recalcitrant, and surprise or act differently to what is expected of them. As I will show during this chapter, teachers and children have their own personal beliefs of how the classroom should be addressed, and what kind of behaviours and ways of being belong there or not. Interestingly, these beliefs are not necessarily aligned with the school's 'educational project', with the school's mission and vision, or with how the 'training of

the soul' is expected to work. In practice, what happens in the classroom is greatly open to variations according to the actors present at different moments.

The dynamics taking place inside the classrooms become crucial, as they reveal how in practice children's agency is expressed in nuanced manners. Children are never fully stripped of their capacity to influence the classroom, but neither are they completely in control of such a setting. Agency is always being foreshadowed, contoured by the other actors who also make use of that space, influencing how relationships can be developed. By the same token, the classroom enables certain paths to be followed, while others become constrained. These arrangements reveal a constant process of mutual accommodation between actors, which encompasses how agency will be expressed and to achieve what purposes. Interestingly, these arrangements occur in a dramatically different way from the one described by theorists and experts critical of the educational model and the use of medication. Daily life in the classroom reveals a different reality, one where instead of thinking about the relationships among students and teachers merely in terms of discipline and coercion, their relations seem better explained by using other metaphors, such as the idea of well-tuned and dynamic choreographies (Cussins, 1996; Thompson, 2005, 2013), which can highlight how even acts of opposition and/or rebellion can be part of a wider, coordinated process of mutual adjustment from where a novel field of experience arise. Novelty emerges as the result of different components and actors playing a role in coordinated dynamics. A fascinating characteristic of this interplay is how actors can adapt and make use of other's capacities to modify actions in the setting, incorporating this as they compose a patchwork of the classroom, arising from the actions and restrictions imposed by all agents who are present (Law & Mol, 1995). There is, of course, a limit to such flexibility of action. Nevertheless, this augmented capacity of adaptation is what better seems to define the interactions inside the classroom, as is this same flexibility which enables the emergence of a potential agency from children, the medication, and the others.

In what follows, I illustrate how this articulation of arrangements, difficulties and interactions takes place. To do so, I proceed to display and analyse vignettes and interviews held during my field work with different actors present in the classroom. In

addition, I also exhibit and further elaborate upon some of the field notes taken during my time in the schools. I mainly focus on participants who were medicated while I was conducting my fieldwork. After all, it is how they can express and make use of their agency which intrigues me the most, and which guided the elaboration of this research project.

Thinking about agency as a shared property

In the fabric of everyday life in the classroom, agency cannot be considered only in terms of influencing adult's actions since, mostly, children's agency is displayed in the shaping and sharing of their private worlds which they carefully try to cover from adult's eyes. By same token, their agency also cannot be reduced to naïve assumptions, such as them being free to fully act based on their own wishes and desires. Rather, it is expressed in how they make use of the limitations imposed by the classroom in order to accomplish things which are somehow meaningful to them. Stimulant medication, I claim, is influenced by both principles previously described. It is not necessarily something children want to have, but that does not mean that is something that forcefully depriving them of their capacity for exercising agency. Medicated children can use the medication to fulfil things that are meaningful to them. Similarly, stimulant medication poses a threat to their private world since it renders the children more visible to their teachers, and to some extent, to their peers. However, medicated children revealed to be able to turn this visibility to their own purposes, as I will describe later during this chapter.

To understand how diverse actors coexist and relate to each other, I will share below two stories I registered during my fieldwork. They illustrate how diverse kinds of arrangements can be achieved in the interactions displayed in the classroom. One story speaks about a girl, and the other about a boy. Both stories are interesting because they allow us to exemplify how agency emerges as a shared property, as the result of coordinated actors engaging and disengaging fluently with each other and with the medication. But also, they reveal how it is not possible to reduce what is happening in the classroom to just one actor. How stimulant medication reveals itself in the classroom and how medicated children make use of the medication is the

consequence of the limitations and possibilities emerging from the context. As Pickering suggests, individuals act in the world and the world acts back on them in a dynamic process he refers to as a 'dance of agency' (Pickering, 1995), that is, the process of continuous resistance and accommodation between material and human actors, in which partners are unpredictably and emergently transformed as the result of these dynamics. In the case of medicated students, I suggest that the use of medication, their peers, teachers, surrounding objects, the school itself, all play a role in how they shape their agency, and in the ways stimulant medication emerges in the fabric of their everyday life.

On 16th April one of the classes I attended was supposed to leave on a field trip to central Santiago to visit some of the city's museums and architectural landmarks. However, because of demonstrations and clashes between the student movement and the police, the School Board decided to cancel the journey at the last minute. The student-led demonstrations attempted to change the current status of the educational system in Chile, a heritage of the Constitution designed by the government of former dictator Augusto Pinochet. In general terms, students from public schools were focusing on changing several conditions of how the educational system tends to reproduce social inequality. Because of that, students were challenging the status of education as it is proclaimed in the constitution of the country. The idea that education should be free for all, and that schools should not be allowed to discriminate and select their students using their parents' income as a selection tool, were some of the claims students were demanding that the government take into consideration. First, this was done in a peaceful and gentle fashion. However, demonstrations quickly escalated into more violent clashes with the police, which were registered by the media nationwide.



Panoramic picture of 'Plaza Italia' during the riots of April 16th, 2015. Plaza Italia is one of the most emblematic places for demonstrations in Santiago. Picture taken from <http://www.ahoranoticias.cl/chile/santiago/minuto-a-minuto-de-la-marcha-estudiantil-del-16-de-abril.html>



Protesters challenging the educational model and requiring the necessity for free education and equal opportunities, during the demonstrations of April 16th, 2015. Picture taken from <http://www.ahoranoticias.cl/chile/santiago/minuto-a-minuto-de-la-marcha-estudiantil-del-16-de-abril.html>

As was the case with most of the private high-income schools in Santiago, the students of Mount Sinai School were not allowed to participate in the demonstrations. When the girls from the 'quinto básico A' were told that their fieldtrip was cancelled because of the manifestations, the mood of the classroom quickly switched from joy to disappointment, to anger. Almost in unison, the girls started jumping up and down, chanting loudly. Oscillating between genuine anger and playfully using the situation to joke and mess around, they start singing songs against the school and the teachers for the cancellation of the field trip. But not all of them joined in with these activities with equal interest. While most girls quickly turned from being angry to accepting the situation, and just sat down after seeing the upset expression on the teacher's face, a few seemed to not really care about this. It was as if they either did not care about the clear expression of weariness in their teacher's eyes, or if they did not realise how their behaviour impacted those surrounding them. One of these girls who apparently could not care less was Antonia.

Antonia is a 10-year-old girl. In a classroom where most of the girls have fair hair, Antonia stands out because of her long black hair and pale skin covered with freckles. With an average build, she is not particularly noticeable in terms of her physical presence. It is her strong and witty personality that initially caught my attention. That and, of course, the fact that she is considered as one of the most 'problematic' children in her classroom. Having been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), she has been under pharmacological treatment for the past 2 years.

While most of her classmates manage to realise that it is time to stop messing around and to return to their desks after a couple of minutes, Antonia keeps rhythmically

hitting her own desk. She continues to do this for a while, mimicking the rhythm of the chant everyone was previously intoning. Some of the other girls start to look impatient with Antonia's behaviour. The expression on the teacher's face also seems to signal that she is not happy with what is going on in the classroom and, in a very traditional approach to the matter, she decides to stand in front of the students with an angry expression on her face, waiting for the girls to stop and sit down. The tension starts to increase, since everyone is already sitting down and waiting for instructions from the teacher to start working. But Antonia does not seem to acknowledge what is happening or, if she does, does not seem to care, although now the teacher is clearly looking at her, arms crossed and in complete silence. After a few seconds, in an attempt to limit Antonia's behaviour, some of the other girls start shouting at Antonia: 'Antonia, cut it out', 'Anto, shut up!' and 'c'mon Antonia, quit it.' Antonia looks around, smiles mischievously and sits down. Only now can the class start.

The other story has to do with a boy. His name is Pedro. He was diagnosed with ADHD three years ago, and underwent pharmacological treatment for two years. At the end of last year, his parents and teachers held a meeting with the neurologist, and they decided that it was time to stop the treatment and see how Pedro would do in school. So, when I first met him at the beginning of that year, he was wrestling with the demands of school without the help of medication for the first time in years.

By the end of my first week at the school, several teachers and students had already pointed out to me how Pedro's behaviour was constantly testing teachers' abilities to handle the class, while simultaneously testing his peers' patience. According to some of his friends, Pedro could switch from being extremely funny and witty to plain unbearable. Alberto, one of his closest friends, usually came to where I was standing and talked to me about Pedro's academic performance, mostly joking about how Pedro normally did not pay any attention to the topics being discussed. 'It's not that he can't focus, it's just that he's not interested. Last year, when he was having medication, he remained still, but he still didn't focus. It's not how the medication works.' When I asked Alberto how he knew that, he smiled and replied, 'because I use the same medication. But I want to have better grades. All my brothers do excellently at school, I want to be like them.'

Almost a month later, the English teacher called me during a class. The children were busy taking a test, which provided me with small window of time to chat with the teachers in the classroom. Alejandra, the English teacher, whispered to me, 'Look at Pedro, and look at Pedro's desk.' He had not even opened the test. He was drawing on his desk which was already completely covered in drawings and squiggles. I went to where he was and asked him if everything was ok, to which he replied, 'Yeah, I just zoned out for a second... this is boring, and I feel like I don't know anything anyway, so, I get bad grades, so I stop even trying to pay attention. Because, what's the point? I'm gonna fail anyway, so I'd rather have fun.'

At the end of that week I attended one of the English lessons again. Amid the usual noise, laughter and movement that comes with most of the lessons in which 10-year-old boys are involved, I realised Pedro was, to my surprise, sitting down and quietly working. This surprised me to some extent, so I headed to the back of the classroom and started observing if anything peculiar was taking place. Alberto, who used to sit in the back of the classroom, was there talking to two other kids. They were laughing and pointing at Pedro. When Alberto realised that I was curious about what was happening, and intrigued about Pedro's behaviour, he mentioned to me that Pedro started using psychostimulants again. Considering his previous behaviour, Pedro's friends thought it was funny to see this other version of their friend. Alberto smiled at me and said, 'This is the first time since I've known him that he actually finished his assignment.' I asked if they thought that this was because of the medication, and if they thought that the medication actually worked, to which he replied, 'Normally the medication does not work much with him.' Probably because of my surprised look, he added, 'You don't get it, you need to make it work.'

Later that day I talked to Pedro during the break. He mentioned that he started taking the medication again. I asked him if he felt somehow different or funny when having the medication, to which he replied, 'I feel like I always do.' 'How is that?' I replied. 'I don't know,' he said smiling to me, 'like a little mischievous I think. You know? You have seen how I normally am.' This surprised me. He looked so different from the outside, yet he mentioned that he felt the same. So, I decided to ask one more question to clarify my thoughts. 'So, nothing has changed then?' I asked. 'It's easier to sit still

during the class. But it's up to me to do it,' he replied, before leaving to play football with his friends.

The above-mentioned sequences of events are examples of the everyday interactions between medicated children and the other actors to be found in the classroom. As can be seen in these stories, medicated children occupy different positions while they engage with other actors. As Antonia exemplifies, at times medicated children can be in a position where they can dictate and strongly influence the actions around them. Nevertheless, just as any other actor in the classroom, her actions and desires eventually collide with other actors. A game of resistance and accommodation then takes place. In the case of Antonia, what stimulant medication helps her to achieve is to better understand how this dance of agency is played, what are the rules that it follows and to what extent they can be bent. Eventually she will have to partially give up her desires, and not everything she wants to do will happen. But she will also manage to conquer new territories. By giving up a little, she will gain the possibility of establishing new social connections, to make new friendships and better take care of the ones she already has. This dance of agency, the constant resistance and accommodation between medicated children like Antonia and other actors is illustrated clearly in an interview I held with the girl sitting next to her in class, Josefina. When I asked Josefina about her impression of sitting next to a medicated child such as Antonia, she reflected about the topic in the following way:

Josefina: [asked about if it is difficult to sit close to Antonia] A little bit, but because she's just too restless (she emphasises this).

Interviewer: So, when she's on medication, is it easier for you to relate to her?

Josefina: Yes! For example, today she was calmer, and she asked me to help her to organize her things, and I don't know what else. So, I went and did it, and said 'Anto, I sorted it out for you,' and she was like, 'Oh, cool, thanks so much that's really nice of you.' She was quieter. In contrast, if I would have done the same, I don't know, a week ago, I think that probably, I don't know, she would have been like (speaking really quickly) 'Oh thank you thank you, oh look at that and this.' She would have been like everywhere. It's confusing!

Just as medicated children can embody this active role exemplified above, at other times they can embody a more objectified position where their actions become more strongly influenced by how others act towards them. Going back to Pedro's story, it is possible to observe how different it is to be under the scrutiny of a teacher than being observed by peers. The first entails for the child to be constantly examined, while their actions are now understood as part of being a child who is bearing with a diagnostic category and a pharmacological treatment. But this is not all wrong, as experts working on labelling theory have expressed in different occasion, arguing that labelling — especially with mental health disorders — causes stigmatisation (Szasz 1960, 1984). In this case, this kind of objectification also carries the possibility of developing a kind of agency which stems from that situation (Cussins, 1996). Being objectified by the teacher grants the medicated child the necessary space, time and freedom to reconstruct himself, to act upon his own actions. While still non-medicated, Pedro can squiggle and draw during a test while the other children cannot, because it is understood that this is part of broader picture which involves biomedical models, school policies, meetings with his family, expert's assessments and a national educational model. When under medication, his actions are also understood differently than the ones performed by non-medicated children. His peers perceive him differently, but the variations are not pinned down to the influence of the medication. As Alberto mentions, stimulant medication becomes a part of a more complex set of arrangements and actors which does not obliterate the medicated children but rather produces something because of the interaction between them. It is only in the interplay amongst actors where new versions of the child can come to light, where a new kind of agency becomes framed. In this sense medication was not considered to be enough to produce a modification in children's everyday lives.

According to my fieldwork experience and interviews, if the use of psychostimulants produces a major variation in the way how a child experience and reacts to the everyday life inside the classroom, what is most normally assumed by the adults in the school is that he or she is overmedicated, and therefore something must be done to interrupt the use of medication. In other words, if adults or children — medicated or non-medicated — have a sense of a major transformation in the child previous self because of the medication, this was quickly attributed to a misuse or overuse of the

stimulant medication. The results expected out of the introduction of stimulant medication in a child's life are subtler, according to what I observed during my fieldwork. Psychostimulants, behaviours, adults and children are expected to interact in nuanced ways, which implies that there is a constant and flexible process of mutual adaptation between the different actors in the classroom. Despite what some scholars embedded in the medicalization of childhood framework argue about the use of medication in such context, psychostimulants are not used to collapse children's subjectivities. Instead, they are expected to allow the emergence of new characteristics from the constraints imposed by the fact of being under pharmacological treatment (Gomart, 2002, 2004). Agency, it can be said, is a shared property emerging of the interaction between the different actors and, despite what is normally thought, children play an important role in how these interactions are shaped.

Stimulant medication and its role inside the classroom

From all the different components and actors which become part of the choreographies enacted in the classroom, stimulant medication plays a highly specific part. The characteristics of its importance are given mostly because of the high expectations that the use of this pharmaceutical drug puts into motion not only in both children and adults inside the classroom but also at a broader scale, which moves outside the classroom itself and translates into wider arenas of opinion and debate. Teachers have their own expectations of how the medication should work, about its benefits and perils and, therefore, deal with the idea of the use medication in different ways. Children and the school's staff also have their own impressions about the subject. Each one of these actors has their own ideas about the role the others play in introducing psychostimulants in the classroom, and to what extent they and the others are accountable for this (Frigerio et al., 2013).

The debate about what is to be expected from using stimulant medication, its potentialities and dangers, has been a matter of constant debate that has managed to find its way out of academic circles, being translated with different degrees of variation to other arenas. Teachers, families, mass media and others have joined the discussion,

making use of arguments originally crafted in the academic circles in relation to whether children should or should not be treated with stimulant medication (R. A. Barkley, 2002; Brady, 2014; Charach et al., 2006; Frazzetto, Keenan, & Singh, 2007; Frigerio et al., 2013; Hawthorne, 2010; Malacrida, 2004; Singh, 2002, 2008; Singh & Wessely, 2015; Timimi et al., 2004).

I already discussed at length this debate in Chapter 1. In a nutshell, the discussion about the use of stimulant medication is torn between those who see this as negative, attributing its use to attempts to control children's actions and behaviours, and those who focus on the beneficial aspects of using the stimulant medication, especially with children who have been diagnosed with disorders such as ADHD — a biomedical category that those opposing the use of medication claim is not real. There are of course some who have suggested that more nuanced analysis of the topic is needed in order to produce meaningful, realistic and less ideological approaches to the subject (Fassin, 2011; Parens, 2013; Rose, 2007; Singh & Wessely, 2015). But overall, these two opposite standpoints manage to gather around them most of the literature about the topic

When it comes to how this debate gets translated in practice in the school, it is possible to observe how stimulant medication has many sides and understandings which, to varying extents, matches the positions found in the academic debate. But how actors in the classroom reflect and act in relation to the medication is sustained not in theoretical debates, but in the lived experiences they get to witness and experience on a daily basis. Alejandra, a language teacher who teaches in both male and female 'quintos básicos' mentions that the way she feels and understands the effects of stimulant medication is based on her experience as a teacher, but that it is also rooted in her experience as a mother of a daughter who has been diagnosed with ADHD. In her opinion, Ritalin is not used to plan and build a 'perfect classroom'. Its purpose is to help children to be able to learn:

In my experience, my daughter is not able to control herself, it's like something overcomes her. She just can't do it, it's horrible (...) Thanks to Ritalin she has been able to improve her academic performance, she has managed... to hold together. She managed to understand when people speaks to her. To be able to sit, and understand what she is reading, you know what I mean? (...) So I

think the same happens here [in the classroom]. It's not that I want to have only doped children. That's not the idea. Because in the end, the idea is for them to participate, to be active. It's not the idea to have children who are overmedicated. The idea is for them to be able to control themselves. It's just that. To control themselves and pay a little attention.

During the interview, Alejandra is emphatic in trying to dismiss the bogeymen normally associated with more radical versions of the medicalization theory, as they have been portrayed in Chilean mass media (Becerra, 2013b, 2013a; Rojas Navarro et al., 2017). It is not about turning children into obedient creatures. It is not about producing a contained, aseptic learning environment. Her insights about how stimulant medication works underscore how by using the medication it becomes possible to foster children's capacity for acting, to be in control of themselves. Her impressions resemble more what is described by Charis Thompson (Cussins 1996; Thompson 2005; 2013) or Emilie Gomart (2004; 2002) when referring to the possibility of developing agency via objectification than to what is normally argued by those embedded in the medicalization theory (Breggin, 2001; Radcliffe & Newnes, 2005; Timimi, 2002). In general terms, in Alejandra's words it is possible to observe how a double movement takes place thanks to the medication: the child goes through an experience of being objectified, his conducts and behaviours are measured and evaluated, and so does his academic performance and ability to interact with others. This objectification performed by adults — medical experts, psychologists, teachers and family members — may produce the outcome of giving medication to the child, or not. Medication then enters the scene aiming to produce a new set of arrangements among the same characteristics that were evaluated in the first place, hoping to produce a renewed sense of agency.

The emergence of this new ability does not aim only to improve children's lives in relation to an academic standard, as it is commonly feared by those opposing the introduction of stimulant medication in the classroom. As I came to conclude, the efficacy of the medication is not to be measured in relation to the academic performance. That is a reductionism to be avoided at all cost. It is the child as a whole who must manifest the right use of the medication. Alejandra echoes this, by reflecting upon the subject in the following way:

When they [doctors] got the right dose [of the medication], I saw how my daughter started doing well. Now she's active, she's involved in the class, but she's ok. I mean, you can get the best out of her. She manages to... sort of connect all that was previously disconnected, I don't know (she laughs). In that sense, Ritalin is not something orthopaedic, is not something fake that is imposed from the outside. Ritalin just helps to reveal something that is already in the child, his essence.

In her analysis of patients attending fertility clinics, Charis Thompson observed how women voluntarily offered themselves to be objectified by the biomedical knowledge embodied in the figure of doctors and nurses. Undergoing a series of standardised biomedical procedures, and with the aid of biotechnology, a new sense of knowledge about their body and its mechanisms could be achieved. That is why she argues that contrarily to what most think, agency is not opposed to becoming an object of knowledge. Being objectified, she claims, can be a way to achieve a new kind of agency. Although children normally do not offer themselves voluntarily to the scrutiny of biomedical knowledge, they also can achieve a new form of agency out of this process. Parallels can be made between both dynamics if we follow Alejandra's reflections. In her opinion, the process of becoming medicated also provides children with a new kind of agency, one that does not aim at fulfilling adult's expectations, but rather at achieving a stronger sense of wellbeing and experience an expansion of their possibility for action in their everyday life:

I'm pro Ritalin because, at the end, you're doing something good for them, to their self-esteem. Otherwise, they keep always playing the role of the fool, because they fall behind. In the end, these are kids that are always falling behind, because they didn't manage to pick up what the teacher said. Because if also the classroom is messy, or there is constant noise, and normally it's like this... that makes it even worse for them. Because yeah, sure, the cleverest can understand anyway. But the child who has difficulties, or that is easily distracted, he's going to get even more distracted, and he's going to understand half of what is being said, and he's going to be left behind. In sum it is a cycle, and then their self-esteem gets damaged, because they realise they belong in the group of 5 students who have more difficulties reading, or to the 5 whose homework is worse evaluated, or to the ones who didn't understand a thing. So, it's a vicious cycle, because after a while they don't want to participate any more because they realise they are doing things wrong. That's how I feel medication can help them improve.

Alejandra's expectations reflect an optimistic approach to how stimulant medication is expected to unfold in the classroom, an approach rooted in her own personal experience. The medication is expected to entangle with the child's selfhood, not producing an obliteration of the self, but rather aiming at producing the opposite effect. Stimulant medication should help nourish characteristics which were previously present in the child, but that were being silenced by less adaptive behaviours in terms of her overall wellbeing. A new form of inhabiting the world is expected to be produced, one produced by the new articulations between certain characteristics of the child which are now being strengthened with the help of the medication, and the environment provided by the classroom. The medication entangles with the child, and a new capacity for agency is produced, enabling the child to produce new arrangements with her environment. For its part, the new contract between the child and her surrounding environment is expected to provide positive feedback in this new order of things, helping to encourage in a virtuous cycle the effects of the medication. It is a new choreography between the actors in the classroom, one founded and guided by an empowered sense of agency originated in the articulation between the child and the stimulant medication.

In a 2013 article based on the results of the VOICES ADHD project, Ilina Singh came to a similar conclusion. She argues that children show significant evidence of agency in their interactions with psychiatric diagnoses, explanatory models and technologies. Stimulant medication comes into play by increasing children's sense of agency, by helping them to 'make more space for reasoning and decision-making' (2013, p. 821). But more important than the specific effect reported by children according to Singh's article, is the fact that most children she interviewed exhibit a resilient sense of self in their interactions with the diagnosis and with the medication. Selfhood is not corroded by the introduction of psychostimulants. They become part of a narrative about the self, where the child is active and creative in negotiation with other actors. In other words, what Singh describes is that instead of being collapsed by stimulant medication, it appears that children make use of it to achieve their goals and develop a better relationship with others and with themselves — what Singh refers to as the interactions between the 'I' and 'the brain'.

But this optimistic view about the topic is not shared by all teachers across the school. Just as in the academic debate opinions are dispersed, ranging between the two previously mentioned poles, in the school some teachers differ from Alejandra's experience. Rosario, a Technology teacher, for instance, feels that medication is something to be avoided as much as possible because of the potential threats it imposes. When asked about how she feels about children using stimulant medication she replies,

For starters, I'm not pro medication. I'm an Art and Technology teacher, and I want them to be creative, to make drawings and move around, I want them to be proactive and have proposals. The medication kinds of numbs you in that sense, it's more aimed for remaining still, and doing Math exercises (...) When they are working with me in the workshop, drawing and that kind of stuff, that's [being medicated] no good for me, you know? Because they are sleepy, they become sort of an isolated entity (sic)... So, I have to constantly be like "ok, wake up, wake up, let's work" (she snaps her fingers while saying this), because they are like this (she puts on a sleepy face, leaning forward, with her tongue falling out of her mouth) when they should be drawing or other stuff... So, I have no use for children like that, you know? I'd rather have them jumping around, but working... and suddenly boom, they make a wonderful drawing, or they cut a piece of wood perfectly, and they get motivated and all... and they go and pick something up or whatever... I'd rather have them like that in my class. Obviously, there is an issue about control... I mean, to have a proper behaviour, but that's the challenge for us. It's about how to do this, to get to know them and win them over, to have them respect you and to work properly, with or without the medication.

Rosario is younger than Alejandra, and her opinion and thoughts are only based on her experience as a teacher. She does not have a daughter or son in whom she can see reflected the effects of stimulant medication in the context of a life span. Her views are valuable exactly for that very same reason: her opinions are founded on and only concern the classroom environment as she experiences it while working there. As is noticeable, she worries about the detrimental effects that the medication can produce in the students. In her opinion, the mere chance for a child to be 'zombified', as she mentions during a conversation interview, is enough to avoid taking the risk of children being medicated. Her description of the medicated child focuses on the potential loss of the child's authenticity. At no point does her description refer to potential benefits

emerging from a child being under medication. In her experience, medication might reveal itself in producing a state of numbness, a loss of whatever it is that spurs the child to be a child. In her account, attributes such as creativity, playfulness, authenticity and originality become endangered when medication comes into play. Stimulant medication is positioned as a way to gain control over the classroom for the teacher, but at a price that she deems too high and that she is not willing to afford: for children to stop being children. Echoes of ghosts stemming from the more radical versions of the medicalization theory are present in her account.

But why do these ghosts keep emerging so frequently when thinking about the medical apparatus, and when reflecting upon its growing ability to explain more aspects of children's lives? Ilina Singh and Simon Wessely (2015) offer a potential explanation to this. They argue that childhood itself has become a powerful and enduring argument against psychiatry and its explanatory models and subsequent treatments, partially because during history, psychiatry has faced difficulties in becoming a respectable science as it frequently has been battling against diagnostic uncertainty, which constantly seems to be remembered by lay people and critics when debating about the authenticity of psychiatry's claims. The very same uncertainties are linked to other portions of psychiatry, for instance, their suggested treatments. As Singh and Wessely mention, this is reflected in some of the current debates, targeting the very idea of the usefulness of diagnostic categories. In their words, 'it [the debate] is more fundamentally about whether or not medical diagnosis is the right thing to do' (p. 661). As they traverse some of the impasses, difficulties and advantages that come attached with the introduction of childhood to a biomedical understanding — and with framing in biomedical terms the child's behaviours and actions — Singh and Wessely stress the usefulness of drug treatment for disorders such as ADHD, but they also manifest the need for other types of intervention to take place. Medicalisation, they argue, has helped provide treatment for children who need it, but also has reminded us of the social and economic determinants underpinning psychiatric disorders, a reason why it is necessary to understand the contextual elements shaping the globalisation of ADHD and its modes of treatment.

Although I agree with them on several points, I find their analysis to be incomplete, and to an extent, slightly overindulgent when it comes to analysing the perils attached to the use of the medication and how medication becomes part of children's lives. Besides, they do not fully consider in their analysis how social expectations about what childhood is end up providing a broader picture for this debate. The considerations about how children should live and experience their life are constantly giving shape to the arguments about the pertinence of biomedical interventions, while they are also influencing how the effects of such interventions are perceived. Didier Fassin (2011) makes a similar statement when arguing that 'the clinical realm is itself permeable to the social world. It is built on scientific knowledge but also in common sense. Medicine is far from being the pure intellectual activity of producing diagnoses and dispensing treatment. It is particular porous to moral categories and moral judgment' (p. 90). Rosario's words are a reminder of how expectations about what constitutes a child's authenticity is extremely relevant in how the unfolding of the medication will be appraised. While her ideas of the coming together of children and the use of psychiatric drugs is one of childhood as a natural state, being threatened and in need of being rescued before they surrender their 'originality' for the sake of accomplishing what adults expect out of them, Alejandra's opinion is located elsewhere. In Alejandra's account the introduction of cultural or techno-scientific elements is not disruptive of the so called 'inner essence' of the child. Her experience is reminiscent of arguments made by Alan Prout (2005, 2011) who claims that the division between 'nature' and 'techno-scientific' elements is nowadays artificial. The actual child is better understood as a merging, a process of coming together of many elements and factors. This entails that a child is not only a human mind and its interactions, or a body and its relationships with an outside world, but rather 'an unending mutually constituting interaction of a vast array of material and non-material resources' (Prout, 2005, p. 109).

Rosario's fears about how stimulant medication might deprive children of some of their core attributes reflects what can be considered as one of the main perils of the incorrect use of psychostimulants: overmedication, or the emergence of side-effects. As mentioned before, the ontological choreographies that are performed in the classroom are extremely sensitive to not only the actions of the elements that

compose them, but also to variations in its components. And of course, differences in how these elements operate also might produce a different outcome for the choreography. Just as the experience of a ballet will vary if the illumination or sound systems are unable to work properly, or as the experience of women in fertility clinics described by Thompson (2005) would have a different outcome if the technological equipment does not work towards endorsing agency, similarly the classroom needs that its components work harmoniously. I will discuss at further length below how overmedication or side-effects of the medication are experienced in the classroom. For now, it is important to remember that the strengthening of children's agency is one of various potential outcome of the introduction of psychostimulants in the classroom, and that there are other potential outcomes. In this sense, it is important to bear in mind that psychostimulants are not a 'magic bullet' to promote children's capacity for action.

If the entanglement between the child and stimulant medication is produced in a virtuous way, it opens a path for beneficial outcomes to happen, as it has been registered by some scientific literature (Singh, 2007c, 2013a; Singh & Wessely, 2015). If this entanglement does not operate virtuously — this is, in tune with the child's previous abilities, aiding him or her at fulfilling purposes that he or she values — detrimental effects may occur (Brady, 2014; Harwood, 2005; Timimi et al., 2004). This might sound simplistic, as it were just a matter of perspective regarding whether stimulant medication is thought to be working properly or not. But things are more complex than this. As Annemarie Mol suggests, objects-in-practice have complex relations, and the relation between objects are enacted in complex practices (2002). The potential outcomes of the relations between the child, stimulant medication and the classroom is not to be reduced to a sum of elements, but studied as a patchwork image. However most existing analyses does not consider this. Normally stimulant medication, the classroom and the child's peers are not studied as actors in the sense I am presenting them. And neither have most analyses framed their argument in terms of how assemblages might operate by fostering or restricting children's agency. Mostly, they tend to see the topic as a matter of cause and effect, this is, the stimulant drug producing positive or detrimental effects in the child. But a new field of analysis opens up when seeing these interactions in terms of multiple actors mutually engaging

in a coordinated dance, where agency can be achieved not because of one specific actor but rather because of how agency is co-constructed as a shared property (Pickering, 1995).

The conditions of possibility influencing how psychostimulants might unfold are vast. Again, how the entanglement is produced is not based only on how the actors in the classroom act. The school and its politics also play a role, as it is expressed in the opinion of Macarena. Being an Art teacher for more than twenty years, she has a vast experience of working in schools. While narrating her experience about the topic of medication and its potential effects when engaging with children, she mentions that

These children [using medication] sometimes need a special way of handling them... and I try, I try... and the things is that I have no clue how to handle them... and I guess that's really the problem here. My problem is that I try talking to them, I try to see how to approach to them... but the tools I have... I feel they are not enough. I feel powerless in many cases. And I have to call Jaime [the psychologist] who is in charge of children with special needs in quinto básico... and why, you ask? Because, either I focus my time on this particular kid, or I give my attention to the rest of the class, but I feel overwhelmed by the situation at times. Sometimes I say to myself "What am I doing here? Please, someone get me out of here," because there are like three of them who are like "heavyweights" in terms of bad behaviour... who sometimes make a mess and then they just say to me "oops, it's just that I forgot to take my medication today" and I really (she emphasises this) don't know what to do!

The lack of guidance and clear internal politics and guidelines by the school is something that most teachers complain about when it comes to reflect upon how to relate to medicated children in the classroom. Although the school provides a few indications when it comes to children diagnosed with ADHD and under medication, in practical terms these indications concern mostly the topic of a differential evaluation in cases where the disorder is indicated as severe by an external specialist — psychiatrists, neurologists or even a clinical psychologist.

In Chile, external advisors such as the ones just mentioned are commonly required to express their opinions in relation to what is the best way the school should address the diagnose and treatment that the child is experiencing (Rojas Navarro et al., 2017). But

this advice is hardly enough to ease the everyday concerns teachers have in relation to the topic. Teachers mostly must make up their own minds, and come up with their own strategies to adapt this advice to the everyday practices inside the classroom. This leaves ample room for their own view of the subject, having to fill the gaps of knowledge and information with their own personal experiences. For instance, contrary to Rosario's idea about prompting creativity regardless of children's behaviour within a certain extent, Macarena mentions that

these are kids that, sometimes, you give them instructions to follow and... you just don't exist to them. It is not in their constitution to follow rules (...) When they are under medication at least you get to have some control. But it's not only control of the [medicated] child, it's also control in the sense of [them] not interfering with the other children... but I think this is sad. I don't know what the specific effects of the medication are, but sometimes I look at them and I wonder "why is he like that? What happened?" and some other kid tells me "he forgot to have his medication."

Macarena's words underscore a different aspect of how stimulant medication is deployed in the classroom. Of course, as is argued by its critics, psychostimulants can be a mechanism encouraged by teachers to regain control. Medication can be used, and was used in many cases that I observed, in the hope that its introduction in the classroom could help to restore order and gain dominance over the class. In this sense, control is another analytical dimension that exists when the medication gets deployed in the classroom, control, in the sense that one expected outcome of its use is for the child to become more able to regain control over him or herself, which also might enable — at least this is the social imagination of it — for the teachers to invest less time and effort in guiding the class. It is hoped that the production of a virtuous entanglement between children and medication will strengthen their capacity to think and, as Singh has described, also to bolster their capacity for decision-making (Singh 2013). Understanding control under these coordinates implies that children's capacity of agency becomes reinforced, or even co-constructed through medication in a multi-determined process that brings together the medicated child, the medication, the environment and his peers. This idea of control is more closely in-tune with the ideals of pedagogy that I encountered in these schools, where guidelines, documents and teachers' accounts seem to agree with the idea that a good student is an active learner,

a child who is collaborative. Therefore, the idea of control that socially circulates within the schools' walls is mostly linked to the idea of the child regaining a certain sense of autonomy, prompting relations with other actors while being respectful of the principles of the schools.

But there is other way to understand control, linked to when the medication imposes itself over the child, producing a sense of numbness or the feeling that they become 'spaced out'. This undesirable kind of entanglement between children and medication seems to mirror the images of the 'zombified children' described many times by accounts inspired by the medicalization thesis and classical analysis inspired by some readings of Foucauldian theory emphasising the idea of surveillance, punishment and discipline (Bailey & Thomson, 2009; Harwood, 2005). When found in this state, it is impossible to make the argument that the child is in control. Even more, according to the ideals of personhood these schools attempt to accomplish, a child in such conditions could be considered as a pedagogical fiasco. The numb child does not reflect control, but docility, that is, one that obediently and systematically surrenders to impositions without hesitation. Although this has been described in ethnographic accounts in educational settings, I strongly believe that in part this is because different schools' ethos deal with this idea differently. As for Mount Sinai and Bethlehem schools, their teachers and staff members emphatically rejected the notion that docility is something to be achieved at all cost. As Rosario and Jaime mentioned, the experience of engaging with children should be challenging, as the role of the educators is to guide their uniqueness, not to crush their originality. As I argued in Chapter 4, the strong emphasis on achieving 'originality' and 'authenticity' mostly shielded children from this potential aftermath of the medication, although it must be stated that this is a potential threat recognised as a reality in other schools, as teachers told me during interviews, when they reflected about their experiences in previous jobs.

Since both potential outcomes are possible, why is it that most popular accounts describe the state of numbness rather than the children being able to be more in control? I think this links, in part, to the fact that classroom is commonly described as a setting where either one or the other is in control. Thinking about the classroom as

a landscape where only one vector tends to impose upon the others — the teachers' desires to conduct the class at any cost — clouds the possibility of observing how small arrangements are always in order, how control is not necessarily linked to docility, and can be the result of actors working together, rather than some imposing over others. According to the interviews held, if the teachers in these schools — once again I emphasise that this is open to variation according to contextual factors — thought that stimulant medication would help to renegotiate and produce a different distribution of how control was being exerted in the classroom, they were open to the introduction of the medication. But, if they estimated that the medication could threaten children's agency, breaking them into docility for the sake of the teacher regaining all control over the classroom, they felt inclined to reject its use. Rosario's reluctance at the introduction of psychostimulants in the classroom is guided by this dichotomy. She feels inclined to search for alternative ways to regain control, ones that do not compromise what she deems is the essence of the child. In her mind, stimulant medication compromises their capacity of agency. She decides to endorse their agency, and give up control at least in the short term, until she can come up with an alternative mechanism to regain control.

But other teachers do not feel that stimulant medication compromises children's authenticity. They feel the opposite way to Rosario. In their eyes the child's agency is actually strengthened by the medication. Since for them choosing between control and agency are not mutually exclusive, they feel free to allow the use of stimulant medication as an auxiliary element in regaining control over the class. However, if they feel that stimulant medication has somehow compromised the child's capacity for action, if the child becomes 'zombified', they feel inclined to remove the medication from the classroom. That is why, in these schools, it was hard to find children in the previously described numbed state of overmedication.

Mostly, teachers exhibit little knowledge regarding the specific ways in which the stimulant medication works. Since it is common practice that parents do not tell teachers that children are being medicated because they fear they might get stigmatised, and the school is not forced to disclose this information because of the same fears, teachers inhabit a classroom with little information about who is

diagnosed or under treatment. Therefore most of them reported that it was hard to know when a child is under medication or not if they do not observe the process by which the child is identified as somehow troublesome or in need of external aid, gets diagnosed, and then medicated. For them it is central to be able to follow this process so they can accurately assess what the medication can do in its interactions with the child, to see how its effects are put into practice. This causes them frustration, as they feel that their efforts could be much better directed if they had more information about what is happening with their students. As María Jesús, a Natural Sciences teacher, mentioned to me while chatting in one of the schools' many playgrounds,

It would be great to have more information about this, because that way we could do something else, something more [to help children], or at least we would know [what to expect], you know? For instance, I just realised a couple of days ago that Gaspi [short version of Gaspar, a student of her attending sexto básico] was under medication because that week he was behaving terribly, not listening to anyone, nor his classmates, friends or myself. You know how I teach that class on Tuesdays and Fridays, right? Well, by Friday his friends were really fed up with him. They didn't want to sit with him because he kept annoying them with little things. So I thought, "Ok, this is weird, something is going on," and when I talked to the teacher in charge of that class, he told me that they [Gaspar and his family] were trying to quit using the medication. But for me, I just realised then that he was using medication. So maybe, if I knew, I would have done something different, you know? To include him, rather than standing in the sideline just thinking "oh, this is weird."

As can be appreciated in Maria Jesús' comment, medication is apparently silent in everyday life in the classroom. Normally, the variations that accompany its introduction are to be guessed based on what they are observing. The guessing process can unfold in two ways: if the child was medicated from the beginning, this is, if the teacher met the child only after he or she was already medicated, the only way in which teachers can perceive the existence of the medication is when its effects upon the child ceases for some reason. This can happen because the child did not take the medication on any given day, or because there is a modification in the regime or treatment the child is undergoing at that moment. The other potential way by which the teachers normally notice the effects of the medication is when a child starts taking the medication. When this happens, reports about the introduction of the

psychostimulants in the classroom are perceived by teachers in relation to a sudden and abrupt change in how the child acts. Teachers acknowledge the child as medicated when he or she is overtaken by the medication, becoming 'zombified', numbed. The vast range of milder effects and more harmonic synergies that can be established between the child, the medication and the context apparently pass mostly unnoticed. As was revealed during my time in the classroom, for most teachers the medication apparently existed only in relation with a feeling of excess. Excess of lack of control, deregulation, movement or noise linked to the lack of medication; or excess of control, of loss of creativity or authenticity because of the excess in relation to the encroachment produced by the medication.

Magdalena, a Maths teacher reflects upon these matters by moving away from the problem of the uses of medication, inserting the discussion into what she thinks is a broader analysis. She points out that

Children have several different edges. As we talk about the role of being a student, or a daughter, or a son, or a mother or a sister... at the end, they're all just roles, and during our lifespan we play a lot of different roles, and I also consider that one is... it's like... in essential things one remains the same, but in other things one changes and can be very different. And I think that in the classroom all of these things play a part. Obviously. There is a thing about interests, that maybe Maths is something a child hates, and suffers while being in the class. Like, "I hate Maths so much, I always do bad in Maths no matter how much I try and study." So, how can you ask that child to be proactive in the classroom, to be involved and enthusiastic? I mean... c'mon, that's not going to happen. Or maybe, this child can think, "You know what? I hate this subject, it's so hard for me to understand anything... but, I really like this teacher, and she's so nice to me... so I'll try harder." (...) So I believe that a class, and the way the class reacts as a whole, is not going to be same if you change the topics or the teachers... so, in that sense they mutate, and you have to understand that there are many edges to that group, and many edges to any child. So that's why having teachers' councils is so enriching, because you get to listen and witness other faces of your students... because you find yourself thinking, "Wow, in my class she doesn't act like that." So, you realise that it is not that they don't give a damn about anything, it is just that they might have other motivations.

Magdalena's words summarise in a beautiful and articulate way the many layers and subtleties that accompany the discussion regarding the medication of children, as I have discussed them so far. Strikingly, she also is one of the few adults in the school who introduces a potential standpoint of the child. She does not reduce children to an activity — i.e. moving, jumping or working —, but she rather endorses them as complex individuals, whose lives are entwined with concerns, emotions, roles and materials. As I will discuss below, the picture Magdalena portrays is closer to children's own reflections and practices in relation to the medication than the way in which most adults and theorists reflect upon them. Her intuitions about how children, medication, and others might reveal different versions of the medicated child seems concordant with some of the views I have described. Children, their agency and the way this is deployed in the classroom are highly sensitive to contextual factors, since agency itself is constituted and embedded in the very same arrangements that are possible in relation to other actors. After all, it is a patchwork, and different pieces constitute different outcomes. Change a teacher, introduce different peers, and the medicated child is prone to change. Next I will discuss how this is enacted according to the medicated children.

Agency as an outcome of assemblages: pharmaceutical entanglements

During a Technology class that took place in April, the environment in the classroom was noisier than usual. Once again during my fieldwork, I am confronted by one of the many everyday realities that can be found in the classroom. This time, a multiplicity of noises come together, continually threatening to disrupt the class. While teachers are often successful in their efforts to deal with this kind of situation, this was not always the case. At times, including mornings like this, noise could rise to the point where it felt that everything could easily break out of control. Rosario, the teacher in charge of the Technology class, starts nagging the students, trying to reduce the messiness of the classroom. *'Don't eat in class,'* she tells Alberto and Gaspar, who keep eating once she turns back. Everybody is talking and playing. Some students are playing with stickers from the *'Copa America Album'*, the continental football tournament being held in Chile in 2015. Others are talking about what they were doing during the

previous break, and some who are in their seats pay no attention to the class, but at least they are not walking around. Rosario looks at me. She appears sick and tired of the situation. After making a gesture of exasperation, she positions herself in front of the class, facing the students. She then commands them to move their desks to create more distance between them, apparently hoping that distance would diminish their eagerness to talk. Her manoeuvre only partially works. As a further effort, she calls Pedro to the front of the classroom.

As mentioned earlier in this chapter, Pedro was diagnosed with ADHD a couple of years ago, being on and off medication since. By the time the episode I am narrating took place, Pedro had been back on the medication for little more than one week, after agreeing that with his parents that it would be better to restart the pharmacological treatment as things were not going well for him after stopping. Mainly, they were worrying about his social behaviour in the classroom, where he was being too impulsive and getting into a lot of trouble because of his mischievous actions, and his tendency to get into strong arguments and bullying some of his classmates. These situations were discussed between the head teacher and Pedro's family who then decided to visit the medical expert in charge of Pedro's treatment, who then decided to resume the pharmacotherapy. After resuming his pharmacological treatment, teachers have constantly been trying to help Pedro to keep interested in class by pushing him to be actively engaged with the activities taking place in the classroom.

'You're going to be my assistant today,' Rosario tells Pedro. 'Your duty is to write the name of anyone who is making a mess.' Pedro nods, grabs a magic marker, and starts surveilling the class. He plays this role playfully. He smiles at his classmates and quietly jokes with them but, also, he starts listing some names on the whiteboard. Because he kept eating despite already having been told to stop, Pedro writes Alberto's name on the whiteboard. Alberto shouts at him, saying that he was not doing anything wrong. But Pedro stays firm with his decision. He seems focused on playing his role properly. Alberto shouts at him, 'Pedro, have you had your medication today?' in an attempt to mock him, but Pedro does not seem to mind the comment at all. Alberto then stands up, and goes where Pedro is standing. 'Please, erase my name from the list. I didn't do anything wrong,' he says. 'You were eating, and that is not allowed,' Pedro replies.

Alberto heads back to his seat. He seems slightly annoyed, but after a few minutes he does not seem to care anymore. After a while, Rosario tells Pedro to go back to his desk and to start working on that day's assignment. As time passes, most children start building three-dimensional models made from cardboard pieces that they recently cut out. Rosario comes to where I am standing and whispers to me to look at Pedro. He is not working on the activities proposed by Rosario. He is looking out the window, while softly chewing his scissors. I ask Rosario what does she think about that, to what she replies, 'You need to keep them interested, you need to get them involved. All children, but especially the ones with learning difficulties.'

'Keeping them interested' is a catchphrase that was regularly used by Rosario and her colleagues, when describing efforts to achieve a 'productive learning environment'. Although different teachers described this in slightly different ways, most teachers shared the idea that for children to learn, their attention should be aimed at the content, and so should their interest. Every little thing in the classroom should be directed to this goal, every material object, every intervention performed by the teacher, and the interactions between the children. These are supposed to contribute — to be subsidiary — to the final goal of learning. Children also should contribute to this, as part of their process of training in accordance with what is stated in the different documents and guidelines. Productive learning, or 'real learning' as one teacher calls it, does not only refer to an academic process. It is also related to developing in relation to the ethos socialised by the schools, while children also acquire in the process the social skills and sensitivities expected from them for being part of the higher classes, and for having gone through a Catholic upbringing.

From its foundation in the early 1990s, the educational institution giving shape to Mount Sinai and Bethlehem schools have made ethical and pedagogical considerations aligned with the particular version of Catholicism that is Schoenstatt. Considering how children are expected to lead their own 'training of the soul', institutional practices and code of conduct have been crafted to propel this development. As mentioned in Chapter 4, from an early age children are expected to develop their capacity of self-regulation. They must learn how to keep their impulses in check, acting according to what is required on every occasion according to their Catholic values. Children are

meant to be unique and free, but they must educate their freedom first, and teachers play a significant role in achieving that. Therefore, discipline is ideally not imposed by an external actor upon the child in these schools. Teachers can nag children, and they can perform different disciplinary measures. However, this is discouraged under the expectation that children will act properly because they will learn by themselves what should be done in each situation. They are expected to realise what is right and wrong by themselves, as the result of a process of personal insight that should start early in life, and continue during their lifespan.

But in practice the expectations that the educational institution has regarding how children should act and behave are constantly under pressure. As revealed in the story previously shared, teachers execute different manoeuvres and techniques attempting to help guide the child's interest towards the academic content. Despite the educational institution's expectation that children can and should self-regulate, this skill appears to need constant external aid. It is possible then to witness an interplay between external elements aiming at aiding the child to develop certain skills, and the ways that in practice these interventions performed by teachers and other adults are received by the child in the everyday interactions in which children are involved. Stimulant medication plays a central role in how these dynamics unfold, and the outcomes they have. Psychostimulants are a core ingredient in the establishment of particular kind of entanglement produced in the classroom — a pharmaceutical entanglement — and they are also key to understanding how through these entanglements agency can be strengthened, produced or dispelled.

A few weeks after the events I previously described took place, I attended an English class. The teacher, trying to keep in control of the class, decided that she needed an assistant to list the names of those playing and talking, hence paying little attention to what she was saying, or that were disrupting other children trying to focus on the class. So, she calls Nicolás to the whiteboard. Also diagnosed with ADHD, Nicolás has already been under medication for two years. He starts gazing at the classroom, attentive to even the minimal amount of noise or movement, and every time he glimpses something, he does not hesitate to list a name on the whiteboard. In no more than three minutes, already seven names have been listed. Nicolás seems proud of the way

he is handling his assignment. While normally he is being teased by his classmates because he is funny looking, and acts a little more childish than most of the class, now he is in a position where he can dictate what is happening in the room. His eagerness to pay attention to the smallest detail of what is happening around him at the moment contrasts with his day to day behaviour. On a daily basis, and despite having the medication, he is normally easily distracted by random stimuli. Additionally, he is one of those children who have a difficult time when asked to remain silent. Whether it is to comment on the topics of the class — which he sometimes adequately does, but most of the times he does not, drifting away to topics of his own interest — or to just chat about anything, Nicolás seems to constantly have difficulties to connect to what is happening inside the classroom and to restrain himself from reacting to whatever happens around him. But now, right in this moment and in this context where he can strike back at those who normally play him for a fool, he seems focused as never before. But his will to excel in his new-found position backfires when the teacher realises that almost 15 names are listed on the whiteboard in less than 10 minutes. ‘Go back to your seat Nicolás, you’re not taking this seriously,’ she says. Nicolás argues that he was only doing what he was told. ‘No, you weren’t, you’re just joking around. Go and sit, and pay attention to what has been explained so far in the class.’ Nicolás looks baffled, while the rest of the class bursts into laughter.

During the same class, another child diagnosed with ADHD caught my attention. Gabriel has been under pharmacological treatment for over a year. However, from the first time I met him, he never struck me as a child whose characteristics and personality traits have been overwritten as consequence of having the medication. Although rather mischievous in his actions in the classroom, he tends to act according to what is expected from children by teachers in such a setting. Only from time to time does he do something that can be considered as out of line, but the rest of the time he keeps up the pace demanded by the teachers. On this particular day, he exhibits some traits of the behaviour that prompted his parents to ask a medical expert for assistance in the first place. While Nicolás is listing names in the whiteboard, Gabriel is sitting down. He splits his time between paying attention to what is being said by the teacher, and chatting quietly with the boy sitting next to him. But once Nicolás is sent back to his desk, Gabriel stands up and walks towards the garbage can. As he walks there through

the back of the room, he kicks the chair where another boy is sitting, making him fall. Gabriel laughs, and so do the ones that saw what happened. Gabriel keeps walking as if nothing has happened. He jokes around, blows his nose, throws the paper tissue away and comes back to his seat. All of this in less than two minutes.

For the following 30 to 45 minutes, Gabriel combines moments of working, where he seems able to focus and be responsive to what the teacher is saying, with others of recreation. But also, he seems to be able to mix both together. As Alejandra asks Gabriel some questions about the proper pronunciation of some English words, Gabriel replies theatrically, exaggerating the intonation of the words, making them sound absurd. The teacher smiles at Gabriel, and he smiles back. Alejandra seems pleased with what just happened, as if it did not matter that he made a joke out of being examined as long as he were able to reply. 'That reveals that he was focused, paying attention on what was being said,' she will later confess to me. For his part, Gabriel turns around and starts chatting with another boy. 'I just love teasing the teacher,' I heard him say. However, there is a limit to how much mockery the teacher is willing to accept. Gabriel keeps up his game of working and talking simultaneously. He seems confident that he is not going to be scolded by the teacher as long as he is properly solving today's assignment. But then he oversteps his boundaries. While trying to copy in his notebook what the teacher has written on the whiteboard, he yells at Alejandra, 'Miss, move over!' She turns, looks at him and replies, 'You can't talk to me like that. Who do you think you are? Where do you think we are?' Gabriel seems embarrassed. His face turns slightly red as he says to Alejandra how sorry he is. His game of teasing has backfired.

The stories I shared above help illustrate the nuanced and complex ways in which pharmaceutical entanglements take place. By this term, I refer to the nuanced processes by which the child and the medication interconnect, becoming something else, something more. It is not just an addition of characteristics — those provided by the child, and the ones induced by the medication. Rather, this entanglement allows for a transformation of what the child can be. This process of hybridisation can lead to different outcomes. It can either produce a transformation so radical that neither the child nor others seems to recognise any traces of his former self after the process of

medication takes place, or it can lead to a process of attunement which allows the child to preserve what he and others deem essential features of a previous self, while also obtaining emergent properties that were not contained either in the medication or in himself.

As the stories reveal, it is possible to observe how the effects of the medication can produce something different from the commonly caricatured images of medicated children, such as those pushed into severely numbed states, or those who are dramatically transformed into model students after beginning medication. But these stories also make apparent how the encounter between child and medication takes place in the midst of other, different interactions that also influence how medication effects unfold. Classmates, teachers, pedagogical techniques, whiteboards, scissors and magic markers, these and more become intertwined in actual classroom settings, the particular sociomaterial context in which pharmaceutical entanglements take place. In this sense, it is possible to observe that the presence of psychostimulants in the classroom is better described as the introduction of a potentiality.

This idea of potentiality reflects how choreographies between contextual factors, biology, technology, and other elements ‘touch ground’. As these elements come together in dynamic ways, they become ‘constructed, undone and redone’ by children, by ‘becomings of actual people — caught in the messiness, the desperation and aspiration, of life in idiosyncratic milieus’ as they transform and adjust themselves to their lifeworld (Biehl & Locke, 2010, p. 337). Stimulant medication does not necessarily entail a reduction of the field of possibilities. Thinking about psychostimulants as a potentiality rather entails that a highly dynamic and open-ended process must take place, a process that might lead a child to become different (Taussig, Hoeyer, & Helmreich, 2013), to become something else, yet still linked to her previous self. This is how a successful entanglement appears to take place according to children and teachers. It should respect what is nowadays considered the ‘naturalness’ of the child, although the idea of what ‘natural’ means might change from person to person (Nuffield Council on Bioethics, 2015). According to what is narrated by medicated children themselves, but also by their peers — who tend to react with concern and astonishment when their friends exhibit signs of being overmedicated — and by their

teachers — following the pedagogical ideals of these schools — stimulant medication should not be perceived as overriding the child's previous version, but rather fostering it. It should enable him to be more in control, fostering his agency and capacity by allowing him to regroup, organise and put into action the different traits of his personhood and conduct.

Colomba, a non-medicated 10-year-old girl who participated in the research, makes an insightful statement in relation to the different paths that medication can undergo. Using a scene from a Harry Potter film, she reflects upon the potential effects that the entanglement between a child and medication can have:

I think that, for instance... ok, I think that the medication that you have for improving your mood, or for focusing or any of those things... they will be good for you if you want to have them in order to be able to do something. But I sort of have the feeling that, I don't know, that they're vitamins that they just put in a jar. And they say to you, 'Ok, if you have them, this will help you focus more.' And you have the medication because you're forced to, and it doesn't work. But if you want to take it because you want to focus more, you'll focus more, and you'll think the medication helped you to do so. In a movie, in Harry Potter, this guy has to audition to become a quidditch goalkeeper. Well, the thing is that Harry gives him some drops that supposedly bring good luck. And this guy believes that the drops work, and he wins. And Hermione asks Harry, 'Did you add the magic drops?' and Harry replies, 'I only pretended to.' But since Ron thinks that he drank the magic drops, he plays as a goalie and he's actually good at it. And he wins. But the reality is that the drops didn't affect him at all, but thanks to them he's able to do it [to succeed].

Colomba's reflection bolsters, to a certain extent, my impression of how these pharmaceutical entanglements take place. She emphasises two things with which I agree after analysing the data gathered during my fieldwork. First, that medication is a constraint. It is not something wanted by most children. But also, she highlights that there might be a benefit to be derived from such constraint. In reality, medication is neither water, nor magic drops. Although commonly viewed by children as lacking attributes powerful enough to force change, psychostimulants do produce something upon the body. The medication is not neutral, it produces modification at a molecular level. In that sense, it is not a placebo. However, the fact that medication produces

change does not mean that it cannot be beneficial. Nevertheless, her opinions about how stimulant medication works shed some light about how from constraints different things can emerge.

An interesting reflection about a similar topic is discussed by Emilie Gomart (2002, 2004) in relation to her research. Discussing the effects drugs may have on those taking them, she suggests that the discussion should be relocated to a field other than the moral realm, as most accounts of the subject are based on what she considers to be a false premise. As she argues, it appears that most accounts start under the assumption that the individual is either an active and rational being, or that he is controlled and coerced by the drugs. Gomart wonders why is it that social sciences have considered the individual as a 'close entity', already formed and complete. In this belief, she pinpoints the main reason why drugs are considered to corrupt the individual. Since actors are normally considered

[as entering] the scene as already formed and filled to the brim with capacities, intentions and desires [,] 'Action', then is the expression of these inherent properties: for this manifestation to be complete, the entities must be the only actors on stage: if others act at the same time, this manifestation is corrupted. (2002, p. 520)

But what if the individual is not corrupted by other actors, but is rather enabled by them, granted certain capacities via these interferences? For Gomart, the answer is simple: entities, such as the medicated child, are not the result merely of human action, neither of the actions forced upon them by objects. The individual is 'the result of practices that frame, embody, localise and temporise' (2002, p. 520). By acknowledging this, the focus of analysis shift from trying to eliminate constrains in order to make the individual autonomous and free, to distinguish what kind of forces, what constraints may act positively, inducing movement. The effects of the medication can be forced upon the child — normally being reported as negative effect — but they can also support the child's interest in acting differently. In this case, the effects of the medication do not just happen. They have to be performed by active agents (Gomart, 2004). Interestingly, agents can also be guided into becoming active, and Pedro makes a fair example of this. Although all children are normally exposed to constant activities to keep them interested and focused during the class, attempts to accomplish this are

redoubled with medicated children. Additionally, teachers are more attentive to the effects such actions have when they are aimed at medicated children. Once Pedro started having medication again, teachers tried by different means to capture his attention, to keep him focused and active during the class.

As Colomba suggested, it is not enough to have the medication. Introducing such an actor in the array of arrangements performed in the classroom makes it necessary for the medicated child to acknowledge the presence of a new constraint, a modification in the choreographic dance that has previously been enacted. But this constraint can work as more than just a limitation. Constraints such as stimulant medication can be generous, they can modify the set of arrangements, and they can induce movement, producing a new choreography. But in order for this to happen, its agency has to converge with that exhibited by the medicated child. It is a very subtle interrelation that takes place. If the medication overcomes the medicated child, and he shows no sign of co-operating with the medication, then its effects are null or adverse. However, if actions induced by the medication are joined by an active agent trying to perform the effects of the medication, a space for novelty opens.

In practice, medicated children are normally guided by their teachers or even their peers in order for the medication to produce its beneficial effects. This guidance works as an external control locus for the medicated children who, despite having the medication, reveal little interest in focusing in the class. This is particular relevant since whether they choose to work with the medication or not, it appears that normally there is always room for their action to modify what is happening in the classroom. Rarely was the medication revealed to be imposing itself over the child, as I illustrate in the next section. But normally, children taking the medication in these schools conducted themselves in the same way that other children do: they fool around, play and talk with their peers. Only a few cases of (over)medicated children presented themselves as negatively constrained by the psychostimulants to such an extent that they would not leave their desks, or that they would behave towards their peers in such a different way that they could become unrecognisable. Normally, the changes related to the introduction of the medication are subtle, and bursts of previous ways of behaving are always on the verge of taking place.

Looking back through practices: ontological choreographies in the classroom

So far, I have discussed how the entanglements between stimulant medication and the child can be performed mainly in two different ways. One can be described as the gentle and nuanced coming together of both actors — medication and the child. When this fit is right, it is possible to witness how stimulant medication serves to foster the emergence of certain qualities upon the child, qualities that are considered desirable and useful by the child and the others that compose her environment. The other possible entanglement that was reported by teachers and students corresponds to when the medication imposes itself upon what is considered the previous version of the child. When this happens, the medication is considered a threat because of the potentiality it carries to modify the child to such an extent that it becomes difficult to recognise some of her previous characteristics. In this sense, it is possible to observe that stimulant medication is neither beneficial nor harmful by itself. The presence of psychostimulants in the classroom is better described as the introduction of a potentiality, a chance for things to be different. However, how this difference unfolds is open to different outcomes, which are dependent and rely on how stimulant medication becomes entangled with the other actors, particularly with children using it.

The idea of stimulant medication as a potentiality is shared by most children I spoke to. In a general sense, they tend to strip medication of any capacity on its own, except when its presence is revealed as a constraint of the previous characteristics defining the medicated child. Being able to focus more or to behave differently cannot be identified exclusively as the effect of psychostimulants. To most children, for this to happen, it is necessary for the medicated child to actively engage with the medication. You must ‘give room for this to happen’, as Colomba, a non-medicated child reflects about her medicated classmates. This becomes clear when looking at daily practices held in the classrooms.

In a now classic essay regarding how individuals become regular marijuana users, Howard Becker (1953) grasped some critical details that previous discussions about the subject seem to have neglected. First, that it was not enough to test the drug in

order to obtain the pleasant effects that regular users normally describe. 'It is not enough,' he says, 'that the effects be present; they alone do not automatically provide the experience of being high. The user must be able to point them out to himself, and consciously connect them with his having smoked marihuana before he can have this experience [of being high]' (p. 238). What Becker notices in his analysis is that when it comes to the uses of (pharmaceutical) drugs, sometimes the act of having the drug is not enough for it to deploy its effects. The user must learn how to connect the physical experience he is having, he must learn how to tune into the bodily and sensorial experiences he is having. Otherwise, as Becker notices, the user normally reports that the substance had no effect at all, or produce an unpleasant sensation. It is only when they are able to locate the sensation, realising that there is 'something different' that they connect their experience with the use of the substance. And from that point on, another action is required. The user must learn to enjoy the effects he has managed to experience. As he points out, an individual cannot continue using the substance for pleasure 'unless he learns to define its effects as enjoyable, unless it becomes and remains an object he conceives of as capable of producing pleasure' (p. 241).

In a similar fashion to the ways described by Becker, the interaction between the child and the medication requires some actions to be taken so they fit together in such a way that is felt to be advantageous for the child. First, psychostimulants require a process of examination to be conducted, their effects recognised, and learnt to be used in favour of producing something. By itself, the medication produces physical signals that the child must learn to decode, to recognise and use in order for something new to emerge. The action of taking the medication cannot be reduced to a cause-effect causality where the medication triggers a novel ability, or breaks down a former self. In this sense, stimulant medication operates as a potentiality, which ranges from a description of their use for coercive purposes, to restoring their control of themselves, hence restoring their true identity and potential (Rose, 2006a). And secondly, the recognition of these bodily and mental sensations that accompany the use of the drug must be learned to be recognised as purposeful. This is, they must be given a meaning, a teleology, a purpose to be pursued that gives sense to the fact of having the medication in the first place. Otherwise, these same bodily sensations can be felt as disruptive, annoying or threatening.

Understanding and taming these bodily sensations for the sake of achieving something purposeful for the child does not entail that what is being achieved is something that adults normally expect out of children in a classroom setting. Neither does it mean that what the child tries to achieve is being done in the way adults traditionally think it should be. This idea is somewhat illustrated by Angélica. By the time the following events took place, she had been under pharmaceutical treatment for the previous two months, after resuming her treatment which was paused during the summer holidays. The reason why she started treatment in the first place was because her grades and overall interest in the academic contents had decreased greatly according to her parents and teachers, which also affected her self-esteem. As she narrated during an interview, ‘I used to do great at school when I was little, but during last year I had troubles getting interested in what the teachers were saying, and by the time I managed to make myself interested, there was already a huge gap between what I knew and what they were talking about. And I hated that feeling, you know?’ When I asked her what feeling she was referring to, she added ‘the feeling of being left behind, of realising everybody understood something and you didn’t, not because you can’t, but because you were [mentally] away for a while, and you have to catch up but now you’re always behind’.

Since resuming her pharmaceutical treatment, Angélica’s grades and self-perception had improved, or at least that is what several of her teachers mention when I interrogated them about the matter. But what was most interesting to me is that Angélica’s presence in the classroom was not exactly the textbook definition of the disciplined child, neither did it match the social imagination of the medicated child arising from accounts grounded in the medicalization thesis. I came to notice this one particular day in early June when during a Spanish class—as during many other occasions—Angélica was sitting down still in her chair. But contrarily to the traditional idea of how children should act—eyes forward, facing the whiteboard, and taking notes—Angélica was looking down, while gently playing with the tip of her long, brown braid. During class she constantly looked like that: absent, self-involved, as if she was dwelling in a world composed of her own ideas. Only from time to time she stopped toying with her hair, grabbed a pencil, and took some notes. The only other thing that disturbed that way of inhabiting the classroom was when she was occasionally scolded

by a teacher. When that happened, Angélica would look surprised, she would sit straighter, and look at the whiteboard for a few minutes, after which she would return to her hair.

I interrogated her about this during our interview. 'How do you feel the medication works for you?' I asked, to which I added 'because most of the time it seems that you're distracted, or like you don't really mind what teachers are saying or doing'. Angélica seemed surprised by my interpretation of what was apparently happening in the classroom. 'you're wrong', she said, 'I am paying like a lot of attention most of the time. The thing is that for me it's easier if I don't look'. When asked about what she meant by 'paying attention', she continued by saying 'last year, in class, we learnt that different persons have different capacities, different ways to learn. Some need to see, but I need to listen. If I look at the whiteboard or not depends if the teacher is nice, or if she's a nagger. I play the guitar since I'm little, so for me it's mostly about listening'. I continue by asking her how the medication helps her to do that, to 'focus' by listening. Angélica seems to have a hard time understanding why it is hard for me to understand how the medication works. So, she puts it in a simple mode 'it's not that weird. It is just that when I have the medication, and I feel it's working, it becomes easier for me to choose what to listen to, and sort of keep listening to that instead of listening to something else. So, instead of thinking about tunes or about a conversation I had with one of the other girls, I can keep listening to what I want to listen to'. 'But how do you know it is working', I asked. 'Because my tummy feels funny, and sometimes my hands feel a little funny as well, like if little ants were walking over them. I feel that after having the medication in the morning'. 'Is it annoying to feel like that? You know, feeling your hands and tummy differently, like itchy...'. Angélica ponders on the answer for a few seconds, to which she finally replies 'not really. Maybe at first it feels strange. But then you learn to realise that it is just how the pill makes you feel, and you shouldn't be scared or anything. It's just how it feels when you swallow it and it's inside your body. Nothing more'.

Angelica's insights are interesting for many reasons. Mainly, her actions and ideas reflect how interactions between the pharmaceutical drug and her own body take place. In her thoughts it is possible to witness how interactions between the

psychostimulant, body and context produce a multi-determined process, where the bodily signals triggered by the drug can work as a call-to-action for the child, a signal that advises the launching of an inner, biochemical process, that needs to be harnessed and put into action. It is not only about recognizing the bodily sensations induced by the drug, it is also about not getting scared by them, so the child can produce a novel sense of control which can be put into action in manifold ways. But there is more to the process than just the body and its interpretations.

Emotional elements also play a significant role in how the actual experiences, practices and meanings arising from the use of psychostimulant medication take place, as has been pointed out by Scott Vrecko (2013). Drawing on his fieldwork experience with university students, he realises that changes in the emotional states of students using methylphenidate are central for understanding how they shape their perceptions of how the interaction with the medication occurs. Among the different findings described by Vrecko, one proves to be enlightening for what I observed inside the classroom: there is a certain feeling of drivenness that comes along with the ingestion of methylphenidate. But this drivenness, which is described by Vrecko as

feeling a strong need or desire to do something' (p. 6) must be channeled. It does not come with a pre-fixed goal. It has to be directed somehow in order to achieve a specific goal. As one of his interviewees narrates, 'I have to make sure to start telling myself "ok, it's work time". This is what you've got to do, this is why you're doing it. (p. 7)

As mentioned, there appears to be no causal relation between having the medication and it producing just one specific result, as the potential outcomes of the interaction between individuals and stimulant medication are vast.

Based on my fieldwork experience, and considering the ecological niche I studied in depth — the one provided by Mount Sinai and Bethlehem schools, with their ethos, background and sensitivities — medicated children were rarely found in a state that could match those descriptions of children in a state of numbness so acute that they resembled 'zombies' (Mueller, Fuermaier, Koerts, & Tucha, 2012) or 'robots' (Singh, 2012). However, this does not mean that this could not happen, as the medication has the capacity to induce such effects. As mentioned before, stimulant medication acts upon the body, producing modifications, which can be experienced in more ways than

just becoming a 'zombie-like creature' (Mueller et al. 2012, p. 104) or what I called 'virtuous entanglements'. They can also produce trigger other potential side-effects that can be a cause for alarm:

After coming back from the break, Mateo looks a little weird. He sits on his desk, and stays there with a funny expression in his face. The teacher in charge of delivering the History lesson enters the classroom. After shushing children, she begins her class. No more than 20 minutes after the class starts, and while the class is busy solving a worksheet with exercises about the arrival of Christopher Columbus, Daniela calls me to where she is standing. As I walk through the classroom, she discreetly points her finger to the boy sitting next to her, Mateo. He seemed uncomfortable and restless. Daniela leans to me and asks, 'He doesn't look well, don't you agree?' After hearing that I agree with her and apparently carefully reflecting about this for some seconds, she kneels next to Mateo and asks 'Hey, you. You ok Mateo? You look a little pale.' Mateo tries to smile, but he only manages to make a grimace reflecting his discomfort. 'Not really,' he replies. 'My chest feels funny, as if my heart was a little too fast.' 'Well, that's not good. Go to the infirmary right away,' Daniela says in a caring tone. She then stands up, and asks another child to escort Mateo to the infirmary. Once they leave the classroom, I ask her what she thinks caused such a thing. 'It's the medication probably. Sometimes kids react that way.' I find this intriguing, and ask her what made her suspect that Mateo was on medication. 'Oh, I'm just assuming because a couple of weeks ago I had to complete a Conner test about Mateo. And if you looked at him today, he has behaving in an unusual way.'

When Mateo comes back at the end of the pedagogical hour, he mentions that he is feeling better. 'Did the nurse tell you what was going on?' Daniela asks Mateo. 'She thinks that it might be because of the medication I had in the morning and because I played soccer in the break,' he replies without giving it much thought, as he seems more focused on what his classmates are doing as they are preparing to leave the classroom since the break is about to start. 'Nevertheless, give me your notebook. I'm writing a note to your parents about what happened. You shouldn't keep using the medication until they talk to your doctor first, ok'? Mateo runs to where his backpack is hanging, grabs the notebook, hands it over to Daniela, and ask if he can go play. She

says yes, after which she immediately adds to please stay calm during the break. I follow Mateo out of the classroom and ask him how he feels now. 'I'm better, it was just that I got scared. It was a weird feeling my heart pumping so fast.' 'Has this happened before?' I asked him 'Not really. I had the medication the year before, but I never felt like this... I hope this never happens again,' he says while he looks from the second floor at the other children playing soccer on the ground level. 'Why did you think this time it worked differently... bad?' I asked him. Without looking at me, as he keeps contemplating at the soccer match, he replies, 'I don't know. I think... all I know is that I started feeling my heart beating stronger, and I freaked out, and I couldn't stop noticing my heart. It felt really weird, bad. But now I'm better... do you mind if I go play?' I smile at him, as he turns around and head toward the stairways leading to the soccer field.

Cases like the aforementioned are also part of the potential outcomes arising from the encounter between a child and stimulant medication. However, it is important to keep in mind — as can be seen in the excerpt presented above — that these symptoms apparently are not what is expected out of the use of the medication by anyone in these schools. In the cases I got to witness during my time in the schools, teachers were mindful that overmedication was an issue, and they seem alert to detecting potential side-effects that could pose a hazard for children's safety. I stress this idea because there seems to be a quick assumption by some accounts that this altered and hazardous state is almost something desired by those working in schools in Chile (Abarzúa & González, 2012; Jaque & Rodríguez, 2011). Although I cannot dismiss such affirmations completely, I do claim that in the schools I attended — with the peculiarities arising from their ecological niche — this was not the case. Symptoms of overmedication were considered by the schools and staff members as something problematic that needed to be detected and tackled as soon as possible, mostly by writing a note to the parents of the child in order to reconsider the pharmacological treatment. As I came to realise, teachers do not want a numbed child. They would rather have an active and participative one, who ideally can play by the rules and become interested in the contents of the lesson. But this is also unachievable being in a numbed state because of the medication. Therefore, overmedication was never appreciated in these schools, according to the interviews held with teachers and staff

members. But overmedication is just one of the potential outcomes medication has, as there are other potential ends.

Whatever the outcome achieved, what seems to be undisputed is the fact that the interactions between the medicated child and the stimulant medication get to be knitted together in very complex ways. What the different outcomes of this interaction reveal to us is that these potential effects do not necessarily just happen, triggered by the mere act of having the medication. These unfoldings are also put into motion depending on how the interaction between stimulant medication and the child takes place. In this sense, both parties play a highly influential role on what can be considered as the overall result, the medicated child as he presents himself in the classroom.

The medicated child seems to be more than just a simple addition of the child's previous identity traits, plus the expected effects that the medication can induce (with these either the ones considered as beneficial, or the negative and unexpected side-effects). Instead of a simple addition, what happens is a recurrent interplay between the child and the stimulant medication, where they constantly relocate and make use of each other in different ways. In this constant process of mutual re-accommodation, the medicated child can learn how to make use of the potentiality induced by the psychostimulants, he can dismiss it, or he can even fight against it. All of these potential destinations can be achieved within different ranges. I suggest that in order to measure the quality of these arrangements it is better not to think of them in terms of simply good or bad entanglements, since medicated children normally do not perform these in absolute terms. Just as Gabriel's activities in the classroom reveal to us, a child can make use of the medication in located situations, and act differently — what can be considered 'mischievously' by the teacher — in others, quickly switching from one to the other in brief periods of time. Gabriel playfully moves from one to the other, being an active learner at moments — a conduct reported as hard to achieve without the medication by his teachers — but also giving himself the opportunity to mess around and engage in activities with other children.

In relation to how the potentialities of stimulant medication have been perceived by wider audiences, Nikolas Rose (2006a) mentions two strong positions which have

clashed and wrestled with each other in an attempt to overcome and impose their point of view over the opposing party, and over the general public. While some claim that the use of these drugs corresponds to situations where coercive methods are being applied via labelling and medicalization mechanisms, others see how stimulant medication becomes part of what he refers to as a 'political economy of hope', where the medication allows the child to regain control upon his actions and body by acting upon the specific molecular anomalies located in the roots of his affliction, thus restoring a truer version of himself. But the actual deployment of the effects of the medication seem to take place somewhere in between these two arguments, and their consideration should not be described in black or white. As Rose (2006a) notices,

It is, of course, important to criticize the use of these drugs as agents of control, to point to their false promises, adverse effects, and bioeconomic rationale. But it is also important to note this wider shift in which such drugs are becoming central to the ways in which our conduct is governed, by others, and by ourselves. (p. 223)

In a similar vein, when I argue that it is best not to think about the problem of the effects of the medication in absolute terms, I refer to the fact that most children with whom I interacted did not act in just one way when it comes to stimulant medication. Despite the expected effects that stimulant medication is supposed to induce, none of them were completely focused and in control of themselves, nor were they totally 'zombified' during the whole class. These outcomes, which are visible to the observer, seem to be played within a gradient. By this I mean that they are better understood as degrees in a continuum rather than clear-cut categories, or discrete states.

If the potentialities of the medication are not exclusively contained in the pill itself, where are they to be found? The answer appears to lie in how new modes of agency can emerge in the interactions that both the medication and the medicated child develop as the result of their mutual interconnections, and as the result of their own multiple understandings. In Gabriel and Nicolás cases it is possible to witness how stimulant medication can foster their capacity to focus. However, how they make use of this increased capacity differs according to their own characteristics. While Nicolás makes a poor use of such ability — according to his teacher — being guided more by his desire to playfully take revenge on his classmates than anything else, Gabriel seems

more skilful in switching from accomplishing the teacher's requirements to goofing around. In practice, what stimulant medication allows them to achieve is not linked to a pre-established ideal of school performance. The agency produced as the outcome of the entanglement of the medication and the child is wide, and it has to be put into action by the child. A 'model student' and a medicated child whose entanglement with the medication can be considered according to his own experience as a 'virtuous' one³⁶, are not overlapping categories. In this sense, stimulant medication can also unfold and be linked to attempts conducted by the medicated child to do things which serves their own interest, and not only to fit what is expected of them in the classroom. Gabriel serves as a fair example of the above mentioned. The way in which he makes use of the medication allows him to fulfil partially what is expected of him in terms of academic conduct, and since he can put up this façade, he can manage to do the other things he wants to do, such as teasing the teacher, playing with his friends or simply joking around. But apparently, he only can get away with this because he is having the medication. This way, it is possible to talk about an 'agency of the medication' and about an 'agency of the medicated child'. Although they can be considered as different and independent phenomena, in practice both appear to be inexorably intertwined together.

On the one hand, the 'agency of medication' corresponds to the new set of arrangements, complicities and entanglements that emerge in the classroom because stimulant medication appears as a new actor in the scene. As mentioned, children under medication are to some extent addressed differently, they are guided into action by their teachers, they are constantly being examined but they are also constantly being given second chances: more time, more space, and more room to 'be' and to dwell in the classroom. On the other hand, with the 'agency of medicated children' I refer to how, after learning to recognise and master the bodily sensations that accompany the ingestion of the medication, a child can make use of the medication to

³⁶ As mentioned earlier, by a 'virtuous' entanglement I refer to an entanglement that is felt as beneficial by the child since it endorses characteristics which are felt as positive by him, or it allows the emergence of capacities that are experienced as beneficial by the child

achieve new things, to interact with those who compose the classroom environment differently, accomplishing things that are considered meaningful by them.

As mentioned, neither of these types of agency necessarily translate into better school performance if not guided towards that direction by the child, which can need help into doing so by their teachers or peers. Antonia's behaviour — described in the previous sub-section — is a good example of the abovementioned. Her presence in the classroom is perceived significantly differently by her peers according to whether she is under medication or not. Without the medication, she is expansive to the extent that her classmates find it difficult to relate to her, she becomes socially isolated and sloppy in many aspects. With the medication, new social interactions appear in her horizon of possibilities. Once she entangles with the medication she can command her acts and behaviours in such a way that she knows what to expect out of the others, and controls what is happening around her. This does not mean that she is going to excel academically. In fact, her grades are only average. But her renewed capacity for agency is displayed in the arena she seems to care the most: understanding how to pull the strings around her in order to misbehave without overstepping the boundaries, and therefore without being nagged, being in control of how, where and when to speak, to play and fool around. This capacity for restraining herself at times is attributed by the teachers to the fact that she is medicated. Because of the same, they are willing to be more tolerant when she stops restraining herself and acts upon her own interests. As aforementioned, in her case teachers are willing to wait a little longer, to be a little more patient. The dance of agency performed in the classroom is modified to a different tune, one where medication seems to play important keys, and where the medicated child can become a virtuous performer.

Conclusions

As I have argued during this chapter, the classroom is a key site to explore how new ontological choreographies arise when stimulant medication becomes integrated in the interactions held by medicated children, their peers, adults and other actors. What is most interesting about the classroom as a specific location to pursue this aim is that, for the many different reasons described throughout this chapter, it enables and

fosters the emergence of specific dynamics and practices where the influence and importance of the medication can be revealed. In this sense, the classroom imposes a certain logic. It is a setting where some characteristics of the child are strongly discouraged, while others are not only required, but also endorsed and encouraged. This emerges in different ways. Teachers and non-medicated children may and can ask the medicated ones to behave in certain ways, to 'act properly' as is expected in the classroom, to remain silent when necessary, and to restrict their urge to do things that may disrupt the 'learning environment' that most teachers so vigorously try to implement.

The idea about a specific learning environment to be achieved was commonly used during my fieldwork by teachers as a comparison point. It is used to evaluate what is happening in practice in the classroom, and to compare it to what is expected to happen in an ideal scenario where everything works, and where children are provided with optimal conditions to learn. The learning environment is hardly ever achieved, and it consists of a mixture of different things that must find their way to co-exist in harmony: silence, but not too much, after all, absolute silence could mean that children are not participating; chatting, but only about what is being taught; respect for the others, which entails the ability to restraint oneself for the sake of those being questioned or participating. But also, a certain degree of active participation in the class, as this reveals interest and motivation to contribute to the learning process.

It is in the context provided by this environment where medication is evaluated by different actors seeking to elucidate whether it has some sort of impact in the everyday lives of the medicated children. Most of the time, adults who are present in the classroom evaluate the medication's efficacy by contrasting whether the medication facilitated a significant change in the medicated child's capacity to contribute — or at least to avoid interfering — in the overall goal of producing and maintain the learning context previously described. This entails not only a certain academic disposition towards the contents being taught, but mostly a specific way of inhabiting the classroom. The idea of creating a propitious learning environment is strongly influenced by the thought that children must learn to understand and master the social relations taking place in the classroom. More than grades, it is how children conduct

themselves in relation to social norms — keeping silent when needed, letting their classmates talk, being respectful of others, being active and participative, etc — which is evaluated to see if they are contributing to create a good learning environment.

However, most of the children participating in this research felt differently about the medication, locating its significance elsewhere. This plays a crucial role, since the ways in which stimulant medication enters the scene cannot be reduced to simplistic formulations. The potentials of the medication are multiple, and the way in which it reveals its effects will rely on how the medication and the child mutually entangle, producing a pharmaceutical entanglement. This process — highly sensitive to sociomaterial factors — will also, in return, become part of the wider choreographies happening in the classroom. It will be incorporated in the fragile and fluid dynamics bringing together the medicated child, the medication, the documents and official guidelines, teachers, material elements of the classroom, and so on.

Stimulant medication does not exclusively act upon the child. It can also act with him, being put into action in creative and innovative ways. An increased capacity to focus does not necessarily lead to better grades. It can also lead to fostering social connections, developing new friendships, or even planning pranks in a more efficient way. As my fieldwork revealed, there is a core, fundamental interaction that takes place. The medication meets the child, and it can be used by him for different purposes, or it can impose itself, collapsing some of the child's characteristics in the process.

Pharmaceutical entanglements can be enacted in different ways. By producing a series of material modifications upon the body of the child, stimulant medication becomes an important factor that alters the experiences of children in the classroom, and the dynamics taking place in the same setting. However, it is important to remark that the child is not a victim of the medication, he or she is not controlled or commanded by it. Assumptions of this are commonly rooted in preconceptions that do not take into consideration children's perspectives, being rooted in what Ilina Singh referred to as 'victimology':

victimology tends to wield children's innocence and vulnerability as a hegemonic "master identity" without an accompanying effort to understand

young's people vulnerabilities in context, or to discover where young people show resilience and, indeed, power. This approach has likely contributed to the astonishing absence of young people's perspectives on their encounters with biomedical paradigms, technologies and interventions in the research literature. (p. 372)

But stimulant medications do not work on their own. Besides, they do not work by simply constraining what children can do, as these constraints can ease the emergence of new dynamics and enable new practices. Children can become active and agentic — although not free — as a result of their hybridisation with the medication. Their entanglement can help them to achieve significant things, or it can go the other way, producing a sense of discontent or discomfort. This depends on how the pharmaceutical entanglement takes place. After all, this is revealed to be a highly sensitive process, in which the child directs what is to happen when taking the medication, in a similar fashion as has been discussed by other researchers (Becker, 1953; Singh, 2013b; Vrecko, 2013). In this sense, the child can steer the potentialities that come to existence in his encounter with the medication to produce certain achievements, to obtain certain results through a set of sociomaterial entanglements and contingent relations. If no intentionality is given to this encounter, to the subtle coming together of this vast array of things, then children normally report the feeling that stimulant medication imposes itself, blurring certain aspects of their former selves.

Chapter 6

From global to local: learning about pharmaceuticals and children through the analysis of practices

Introduction

ADHD, psychostimulants and representations of children in Chile

The sociocultural embeddedness of psychiatric diagnosis and medication

New ways to think about agency in childhood studies

Pharmaceutical entanglements

Conclusions

Introduction

Throughout this thesis, I have proposed an alternative standpoint to evaluate the growing prevalence of ADHD in Chile during recent decades, while also paying attention to the increase in consumption of pharmaceutical drugs such as psychostimulants as the first-line treatment for dealing with symptoms associated with the disorder. As I argued in the first chapter, current psychostimulant consumption in Chile has experienced a significant increase in the last decade. However, this increase has not happened without opposition. My description in Chapter 1 reveals Chile to be a paradoxical setting for ADHD: while prevalence and consumption rates keep increasing, challenges from lay people and experts are being made more frequently, challenges targeting the alleged biological underpinning of the disorder, and the subsequent biologically-grounded modes of treatment. This builds a complex scenario, where clashing forces keep disputing the legitimacy of ADHD, and the pertinence of pharmaceutical treatment.

It is in relation to this dispute that I have repeatedly argued for the need for a more nuanced form of analysis of the topic of ADHD and stimulant consumption. It is not my aim to solve the long-standing dispute over whether ADHD is a 'real' disease or not. Nor do I intend to argue in favour of pharmaceuticals as the first or best option for treating the disorder. The aims and scope of my thesis are to be found elsewhere, not

in the analysis of the macro-level, but in how psychostimulants, psychiatric diagnosis, culture, and socio-material elements become entrenched in the everyday life of children in a specific time and place, where specific expectations about these children unfold. This is because engaging with actual children in their daily routines is — I come to conclude — the only way to advance knowledge of how the medication affects, to different extents, their everyday lives. To do so requires paying special attention to children, and to consider them as valid and competent social actors who are not merely being shaped by external dynamics that are out of their control, but rather as actively engaging in their own production. Children, I have realised, not only play a crucial role in their own making-up (Hacking, 2004, 2007), but also become relevant actors in shaping the world that surrounds them, and the dynamics that are comprised in inhabiting a particular context. In that sense, this thesis is a first step to understanding how pharmaceuticals work in the real, everyday lives of children. I consider this to be the foundation stone upon which future decisions can be later made, in other contexts, and for different purposes.

As for the aims of this final chapter, instead of merely presenting a list of the different findings and conclusions that I encountered while conducting this research, I will retrace the path followed by the research question that encouraged this inquiry. To do so — and in light of the discussions that animated the five preceding chapters — I formulate four key themes that help clarify the overall arguments resulting from this thesis. These key themes also help to show the main theoretical disputes that my project dealt with, the points I tried to make, and the novelty of my findings. The key themes are the following: ADHD, psychostimulants and representation of children in Chile; the sociocultural embeddedness of psychiatric diagnosis and medication; new ways to think about agency in childhood studies; and pharmaceutical entanglements.

ADHD, psychostimulants and representations of children in Chile

In Chapter one, I began this thesis arguing how ADHD and rates of stimulant consumption have configured a problematic situation in Chile during recent decades. It is publicly known that, worldwide, social scientists and lay people have been worried about growing trends of ADHD since, at least, the 1980s. But, in Chile, this discontent

took longer to surface. Although Ritalin — the name by which methylphenidate is mostly known in Chile as it was the first commercial branding that arrived in the country³⁷ — entered Chile during the 1960s, historians such as Jorge Rojas (2010) have reported that it was during the years following the coup-d'état perpetrated in 1973 by General Augusto Pinochet that Ritalin became more noticeable. And it was only in the decade of the 1990s that rates of prescriptions rose to such a point that the idea of a 'Ritalin generation' became widespread (Rojas Navarro et al., 2017).

The ADHD conundrums in Chile today have a public facet and a more private, intimate one. Publicly, it is possible to witness how, more and more frequently, the very diagnosis of ADHD is being challenged in mass media. This adds to academic publications, mostly conducted by critical psychologists and other social scientists, who have raised their concerns about different aspects of the disorder. Overall, it is possible to see a change in the way mass media has portrayed — and lay people have perceived — ADHD and psychostimulant consumption over the years. While in the 1980s it was possible to encounter headlines urging parents to bring their children to see a psychologist or medical professional to get a grip on their behaviour, by the 1990s controversies around the effects produced by the medication were already beginning to propagate like wildfire. By the 1990s, the controversy of what were the real effects and perils of the medication were already instilled in Chilean society (Jaque & Rodriguez, 2011). Fears linked to the lack of knowledge regarding how the medication might affect children over the years began to co-exist with the idea that ADHD was caused by biological causes, and therefore it had to be treated 'biologically', this is, by taking medication. Antithetical positions such as the above mentioned have persisted over the years. Currently, as I argued extensively in Chapter 1, these remain similar, because regardless of where people stand in the ADHD disputes, in Chile ADHD continues to be mostly an unclear category surrounded by an aura of mystery and uncertainty.

³⁷ As previously mentioned in Chapter 2, in Chile people commonly talk about Ritalin when talking about pharmaceutical medication aimed at treating ADHD. Only lately and scarcely have people started saying Ritalin when referring to that specific brand, partially thanks to the popularisation of other brands such as Janssen-Cilag's 'Concerta'.

My claim is that because scant data and research has been produced to think about the national determinants driving the surge of ADHD in Chile, attitudes, perceptions, and decisions in relation to ADHD and psychostimulants seem to rest largely upon social representations of childhood. In this sense, as Ilina Singh and Simon Wesseley (2015) have argued, childhood has become an incredibly powerful argument against psychiatric diagnosis. By this, they seem to refer to the idea that the notion of childhood itself seems to be so overloaded with preconceptions that have accreted over time, notions of childhood going all the way back to Modern times, which argue that children are precious, pure and innocent creatures who need to be kept away from attempts at civilising for as long as possible (Lupton, 2013, 2014). As Singh and Wesseley argue, 'childhood' stands for a certain set of values which are held dear, and that are in risk of becoming threatened by the 'civilising forces of modernity' embodied, not without difficulties, in the still imprecise and vulnerable science of psychiatry.

Singh and Wesseley's argument can be simplistic. Undoubtedly, there is more behind the reluctance to medicate children than only certain ideals about innocence and purity keeping psychiatric knowledge at bay. Some of these concerns seem to respond to a certain cautiousness in relation to the extreme fragility and malleability defining the borders of what can be considered as a mental health disorder, while others seem to be connected to the hesitation in relation to whether pharmaceutical drugs are the better way to proceed (Rose, 2006b). At least in the Chilean context, it is not so much about shielding children from psychiatry and the medical apparatus, but rather about carefully thinking about alternatives to pharmaceutical treatments (Rojas Navarro et al., 2017). In other words, it seems that, more than ADHD, what it is being strongly contested is the social imagination of reducing treatment to drugging children, action that is perceived as a quick fix, and against which alternative approaches have emerged (Rojas, 2010).

The fear of how medication might change or modify the alleged true, inner self of the medicated child is what I refer to as the private and intimate face of ADHD. Private and intimate, since it is what was expressed at times by teachers and school staff during fieldwork. Building upon their own experiences and beliefs, they felt inclined towards

endorsing or discouraging the use of medication according to what they believe childhood is supposed to be like, and how children should act and live their lives. This was expressed in how they conducted themselves in everyday practices involving children. To some of them, children and medication should be kept apart from each other as much as possible, while for others, medication is a way to help children flourish, to aid them in regaining control over themselves, and in encouraging them to fulfil their potential.

It is possible, I believe, to piece together the current ADHD dispute — as it is exhibited in the Chilean context — in accordance with these two different standpoints. Throughout this thesis, I have argued that social science approaches such as those inspired by the medicalization thesis are too deeply embedded in what has been called by Alan Prout and Allison James (1997) the ‘dominant framework’, which influenced sociological accounts of childhood in the 1950s³⁸.

Broadly speaking, the dominant framework gathers together two different sentiments towards the child. On the one hand, it considers childhood as a formative stage where children are to acquire and develop those traits that will enable them to become fully human — or fully adult. But on the other hand, this conventional vision of children, heavily influenced by religious and romantic visions of the child, cherishes the child’s innocence and naturalness. And in my account, this is precisely what lies behind the reluctance, in Chile, of mixing together children and biomedical spin-offs such as psychiatric diagnosis and pharmaceutical treatments. Although on one level teachers, parents and school staff think and act toward children as individuals in the process of becoming adults, ergo as in need to be educated, guided and — sometimes — scolded or punished so they can learn; on another level the same adults surrounding the children defend and champion childhood as a place to be innocent, to be free, to be ‘a child’. Of course, these versions of the dominant framework also get affected by

³⁸ I do not intend to review here how constructions and reconstruction of childhood have developed through recent or ancient history. There is a vast and rich tradition of scholarship attending this matter, that can be traced all the way back to Philippe Ariès’ remarkable piece *Centuries of Childhood* — originally published in French: Ariès (1975). *L’Enfant et la vie familiale sous l’Ancien Régime*. Paris, Editions du Seuil — and from that point on. For an interesting and rich review of how different understandings of the child have succeeded from the 18th century onwards, see Hendrick, H. (1997).

different ecological niches where the diagnosis and the medication is being used in Chile. After all, it is a country where Catholic heritage is still a strong component of the ways in which children are considered, a heritage that is not unified, as Catholicism has different sides and versions according to different locations, economic backgrounds, cultural status and, therefore, schools; and where recently some portions of the population proudly flag their secularism as evidence of their modern ways and international influences.

Contrary to most accounts about ADHD in Chile, I have moved away from the social representations of the children as frail, natural or innocent. I have done so because 1) such an approach does not think about children as valid social actors because of their immaturity, and 2) they think about children mostly in terms of processes of socialisation and therefore pay little attention to how children deal with external influences in their everyday lives. In other words, they put their attention on the macro level but show little interest to how these dynamics become translated into daily realities, which is particularly problematic since the macro level does not represent or express children's voices or points of view

That is why, during the empirical phase of my thesis, I decided to adopt a methodological approach which could show solidarity with the children's accounts and multiple voices. Given my interest in knowing how stimulant medication cut through and became part of the daily routines in which children took part, I thought that it would be enlightening to observe and ask about these dynamics to medicated children themselves, their classmates and those who are constantly present when these practices take place. Instead of taking as a given the idea that medication is something to be avoided since it corrupts something in the child — a view deeply influenced by the natural and romantic perspective of the child I previously discussed, and which is pervasive in the medicalization thesis, as Prout (2005) has realised — I chose to pose a question. My aim was to attempt to locate the analysis not in the abstract discussions about children, but in their everyday lives with the medication and in the practicalities that such an introduction involves. In doing so, a whole new array of data became available, that located my conclusions closer to post-humanist theories about interacting agents and subjectivities, than aligned with traditional sociological or

biological accounts about how and why medication does or does not work. But to take a stance as I did entails a different representation of children, one that sees childhood

(...) as neither “natural” nor “cultural” but a multiplicity of “nature-cultures”, that is a variety of complex hybrids constituted from heterogeneous materials and emergent through time. It is cultural, biological, social, individual, historical, technological, spatial, material, discursive... and more. (Prout, 2005, p. 144)

During Chapter 5 I explored in detail some of the consequences that emerged from adopting such a perspective about the child. But also in Chapter 1 I explored the idea that a new perspective about children was required; one that allowed researchers to reflect about the idea that children are neither culture nor nature, but both and more. However, in practice, I ran into several limitations of this idea, which made me realise how deeply entrenched in cultural life is the notion of children as ‘the cultural other’ of the adults (van der Geest, 1996), otherness which is expressed in a set of values hard to challenge in everyday face-to-face interactions with adults surrounding those children who participated in my research. And this very idea — I came to realise — is what prevents some social theories to be translated into producing new understandings about childhood. However, and as I conclude in Chapter 4, these very same social representations of childhood are not themselves unified in just one global understanding of the child, of ADHD, or of how medication should work. They present several variations that, although they may be minor, inspire different understandings of the way in which these elements can and should interconnect in everyday life, granting the possibility of different trajectories as they open the way for a different social life of the medication and of the disorder.

The sociocultural embeddedness of psychiatric diagnosis and medication

Reflecting about the shifting landscapes that psychiatric knowledge and psychological language have faced in Iran, anthropologist Orkideh Behrouzan concludes that Iranian psychiatry — but presumably not only in Iran, but everywhere, although in different ways — performs ‘within a nexus of material and moral conditions wherein psychiatric medication can facilitate medicalization of experience while also providing relief’

(2016, p. 212). I find Behrouzan's reflections acutely insightful to think about the wide variety of ways in which psychiatric knowledge and medication, in practice, always seem to traverse a series of processes of adaptations and modifications when deployed in specific cultural settings. There is a sociocultural and material variability that it is important to keep in mind since medication and mental health diagnosis do not take place in a vacuum where no other forces can intervene.

As I explained during Chapter 4, taking stimulant medication is an act brimming with meaning. In light of data gathered while conducting fieldwork, the use of stimulant medication cannot be reduced to a thoughtless action, neither by the children using it nor by their parents or other adults involved in the process. Psychostimulants are given for a reason. They come attached with a certain purpose, as they are always expected to do something, to change something, to modify something. And these expectations do not rest only in the hope of a biological change taking place inside the body of the child. Prospects of how the medication's effects should reveal themselves travel beyond the limits of the body, beyond its chemistry and composition, as they are expected to be displayed in social actions and in changing ways of behaving in determined contexts. But also it is crucial to realise that expectations in relation to the medication do not only concern adults. Thus, adaptation and academic performance are not the only reason driving the process.

As this thesis has demonstrated, children can also see the act of having the medication as a process which can be highly purposeful. How they attach their own beliefs and hopes in relation to how the medication is expected to work becomes, to a significant extent, a key ingredient in how they become entangled with it. Because of this, most children do not merely take the medication without hesitation, or without constructing and deploying an inner narrative about the medication. In a similar fashion, as has been described by those such as Emily Martin (2009), children also establish links with their medication, although they do so differently from the adult bipolar patients described by Martin. Nevertheless, as I demonstrated in my analysis, children also wonder about what is going to happen once they start using stimulant medication, how it can change their everyday lives, and what can they get out of taking the medication.

The debates about how psychiatric diagnoses can change according to different sociocultural environments are not new in social sciences. And if they teach us something, it is that despite a certain propensity by biomedical and scientific knowledge to think about their models and explanations as universal and culture-independent, these categories, labels and treatments reveal to us how cultural localisations operate as a factor to be always considered. In thinking how the global and the local interlink, Susan Reynolds Whyte and Sjaak van der Geest (1994) suggest that colonialism, imperialism and new modes of trade and communication have bolstered the dissemination of ideas and things — such as medical categories and treatments — worldwide. However, their dissemination is always limited. Their universality is always being moulded by cultural factors. For instance, according to their case study, ‘(...) injections are now available all over the world, but the ways in which they are provided and perceived are locally patterned’ (p. 138). It is impossible — they add — to pay attention to and to understand these kinds of phenomena without paying attention to both processes, this is, the global and the local.

Questions such as how severe symptoms must be in order for the diagnosis to be performed, or how these symptoms are being evaluated, measured and weighed against ‘normal’ behaviour are dependent on how normal behaviour is being conceptualised in each context. Also, one can wonder how cultural factors become involved in spreading a mental health diagnosis such as ADHD, or in popularising a biomedical treatment such as the use of methylphenidate. As I have argued throughout this thesis, I believe that these questions can only be answered by understanding the complexities of how a mental health disorder becomes local, and hence permeated by contextual factors, with the benefits and shortcomings arising from this dynamic (Graf & Singh, 2015).

Considering this, it is worth noting that a particular psychological landscape hosts the schools where my research was conducted as practices and language in relation to both ADHD and stimulant medication are extremely sensitive to sociomaterial factors. After all, it is a completely different experience to be diagnosed with ADHD if you are attending a school in one of the high-income zones of Santiago, than to be diagnosed with the same mental health disorder in one of the many vulnerable boroughs of the

same city. Similarly, to be treated with stimulant medication in the high-income cone entails different consequences and experiences than to be treated with the same pharmaceutical drug elsewhere. Different psychological grammars (Behrouzan, 2016) are offered in both cases, psychological grammars understood as the intermingling of the available psychiatric language, and the everyday practices by which this discursive repertoire is put into action, impacting actual lives, the lived lives of children.

This study revealed that ADHD is not a culture-free label, which can travel from psychiatric manuals and handbooks to everyday life and stay pristine, untouched by context and human affairs. Notwithstanding its biological determinants, and contrary to what is argued by predominant biomedical approaches to the subject, ADHD goes through a process of accommodation to the cultural settings where it is being used. It is important to remark that this process of accommodation does not render ADHD invalid as a biomedical category, nor does it prove the inexistence of the disorder. As Ilin Singh (2011) summarises it, behavioural interpretations are — to some extent — always culturally relative, and diagnostic practices also index social values. And because of that, we should ‘(...) pay close attention to the environment and acknowledge, in a systematic and reflexive way, the substantial traces of context and culture that behavioural interpretation, and behaviour itself, carry’ (p. 895). And if we do, a precise scenario appears to us in this study: an educational institution encompassing twin schools which are deeply embedded in the neo-Catholic tradition widely diffused in the Chilean elite.

The importance of the context lies both in rendering certain understandings of behaviours available to children and adults on the school premises, and in suggesting dynamics and modes of dealing with the psychiatric label and treatment. In other words, context becomes central to providing an understanding of the factors driving the diagnostic process and to understand how the school deals with diagnosed children, and how they understand and expect the medication to work.

Frequently, critical accounts about the topic in Chile claim that ADHD and the subsequent use of stimulant medication are either a way to normalise and adapt mischievous children or that ADHD is the product of an educational system that requires children to stand out, to academically excel from a very young age. However,

as I demonstrate in Chapter 4, neither of the afore-mentioned processes seem to fully apply to my case study.

Undeniably, schools generally aim to see their students thrive academically. But mostly, grades only become a real concern for children and their families during the last 4 years of the schooling process. In Chapter 1 I extensively discussed how ADHD diagnostic rates in Chile seem to peak in quinto básico — the children with whom I conducted my fieldwork — and in octavo básico. This is because 8vo básico is considered a transitional year to adapt to stricter academic criteria, since starting from the following year, grades become a key element for applying to universities. In that sense, making an overall statement, it is possible to partially agree with Chilean critical accounts of ADHD when it comes to understanding why children in 8vo básico are more likely to acquire the diagnosis. However, explaining the prevalence of ADHD in these schools exclusively in terms of academic expectations seem to be implausible. To explain and understand the lived lives of the children that took part in this research, and how ADHD and stimulant medication became part of their lives, we need to look elsewhere. We need to pose more complex questions. To credit everything to unrealistic academic expectations arising from a challenged academic model such as the one implemented in Chile (Bellei, Cabalin, & Orellana, 2014; Urzua, Domic, Cerda, Ramos, & Quiroz, 2009; Valenzuela, Bellei, & Ríos, 2014) seems to be a dangerous cliché. And clichés can be treacherous as they shut down meaning and prevent us from taking a closer look (Jain, 2013). Sometimes, what is needed is precisely to avoid the cliché in order to explore again the same old questions — i.e. what are the effects of the medication? Or, how do children relate to using medication? — this time with an open mind.

In this research, the diagnosis and use of medication emerge in a scenario where multiple threads intertwine and come together, giving shape to a unique landscape, and to a specific psychological grammar. This has implications that are worth noticing. First, that ADHD becomes not so much an ‘academic disorder’, but a social one. By this, I refer to how ADHD is mostly considered by medicated children and their peers in Mount Sinai and Bethlehem schools as a condition that gets in the way of developing a successful or fulfilling social life. Of course, academic life still has a specific value for

children. In fact, most of them reported that grades were important to them for different reasons. But academic excellence is constantly overshadowed by the relevance of the social bond. In that sense, medication's expected effects were not exclusively linked with boosting academic performance, but rather with enabling a different kind of social connection with others, and with producing a different kind of relation with oneself. Medication has the potentiality of developing a new sense of value, a different and sometimes kinder notion of how much children are worth to their own eyes. In that sense, medication can sometimes help bridge the gap between school, familiar, and self-expectation, and the feedback children obtain from their everyday settings. It is still to be discussed how these expectations work, and whether if they are justified or not, or if they suit the child's best interest, but each of these questions is worth a study on their own. So, for now, I choose only to mention them, while understanding and describing how the medication works in the contextual setting where my fieldwork was conducted.

As argued in Chapter 4, each school underscores different traits in relation to what kind of subjects they are trying to produce as the result of their academic and moral training. And in the scenario I witnessed during my fieldwork, these two schools — Mount Sinai and Bethlehem — cherish social and moral characteristics above all. When referring to a particular psychological grammar, I aim to make explicit how behaviours, conduct and actions become understood in a particular manner thanks to, and because of, being part of these schools. The Catholic heritage permeates the biomedical model of ADHD, while also providing the landscape to understand the potential effects of the medication. Self-control, and being able to delay immediate satisfaction, become personality traits with redoubled importance, as they are considered central features of a 'Catholic identity' that, allegedly, can be traced down to Jesus — in the case of boys — and to the Virgin Mary — the role model for the Catholic female personality. Additionally, children are expected to be kind and generous, to be compassionate, and 'sacrificial', that is, willing to serve others and to put others' interests above their own. For its part, being part of the selected group of elite schools implies that certain codes of conduct need to be achieved. Sociability becomes a central element, especially considering how Chilean elites constitute themselves.

As becomes apparent, Schoenstatt's version of Catholicism flags some moral and psychosocial characteristics as more relevant than others, in the sense that they become core elements for embodying the good Christians children are expected to become. And, in perfect synchrony, some of these very same characteristics have also been underscored as desirable identity traits to be trained and secured during life, since they seem to grant access to the possibility of remaining part of the elites. These are elites that, as I described in Chapter 4, feel and are inclined to act much in harmony with principles emanating from the ethos of neo-Catholic movements since the Chilean dictatorship. The articulation of both these trends interpenetrate the 'pure' biomedical model and understanding of ADHD and medication — as if a 'pure' version of the diagnosis existed. After all, it is highly debatable to even think that a mental health diagnosis could ever be detached from its cultural context. And because of that, I argue during Chapter 5 for the need of a thick description of ADHD, since it is only by linking together the diagnosis with its sociomaterial determinants that it becomes possible to understand what is hiding behind the label of ADHD, and what medication is expected to do in order to think about it as being 'effective' or 'successful' for adults and experts interested in the medicated child.

But for children participating in my fieldwork, the success of medication normally came attached to producing a renewed sense of agency, a sense of being able to be in control of their daily lives, or to be able to impact and modify things occurring around or inside them. The link between medication and children was revealed to be knitted together by this sense of agency. However, thinking that external substances can help us to transform into creatures more in control of our lives has been a highly contested idea. And as mentioned earlier, it has been an idea condemned by many when it comes to childhood. But this might change by realising that interconnections between children and medication are more complex than critical literature normally credits them to be. But to do so, we need to think about agency differently, as property not owned by anyone, but emergent within interactions.

New ways to think about agency in childhood studies

Unquestionably, agency is a tricky concept which has been a matter of debate for decades. Endowed with a long history and different understandings, agency has slowly but steadily become a central concern for researchers working in social sciences (Asad, 2000; Emirbayer & Mische, 1998).

When it comes to childhood studies, agency became a major topic of reflection only with the emergence of the new social studies of childhood, which flourished in the last decades of the twentieth century (Oswell, 2012). The interest in children's capacity of agency was initially sparked and guided by the idea that children's lives and everyday experiences matters and should be studied as something valuable on their own terms (James et al., 1998; James & Prout, 1997). Attempting to rescue these experiences, researchers and scholars started searching for the undeniable effects that children's actions have in the social landscape they inhabit, as they are also part of society and culture (James & Prout, 1997), while also placing attention on the importance of rescuing children's voices to bolster their inclusion in policy matters (Hallett & Prout, 2003).

The agentic-centred approach to children spurred by the new paradigm in childhood studies presented a thought-provoking option for thinking about the interactions between children and medication, mostly because it provided a different approach to the one suggested by traditional accounts giving rise to the medicalization thesis. As I have argued through this thesis, the main shortcoming with traditional approaches lies in their unquestioned assumption of the child as a creature than can only be corrupted by the medication. This is because traditional accounts are embedded in what Affrica Taylor and Mindy Blaise (2014) have called 'romantic humanist notions of pure nature' (p. 378), which portrays the child as natural, innocent, pre-rational, pure, and in need of being protected from the civilising forces of modern society.

Bearing in mind such assumptions and preconceptions, it does not appear odd that, although insightful and useful for exposing how biomedical knowledge and practices can and are at times used to support forms of social control (Conrad, 1976, 1992; Harwood, 2005; Radcliffe & Newnes, 2005; Vrecko, 2010), the medicalization thesis is to a large extent unfit to handle the practicalities arising from current and novel interactions between individuals, biomedical discourses and pharmaceutical drugs. In

my case study, these shortcomings are expressed mainly in their incapacity to deal with two things: first, that children proved to be more than just docile bodies, or, to put it differently, children played an active role in making sense of their life, and therefore of the medication; and second, that medicalisation practices take place in specific sociomaterial contexts. And these sociomaterial landscapes play an influential role in how children make sense — and make use — of the dynamics in which the medication is involved.

Sadly, the emphasis of the new paradigm on children's agency is not enough to understand current and complex interactions between children and medication. Although noteworthy, an unfortunate consequence of their eagerness to reconstruct the very idea of childhood in current societies for the sake of creating more inclusive processes of decision-making, agendas and policies (Prout & James, 1997; Tisdall & Punch, 2012), is that frequently their analysis overestimates children's agency to the detriment of other potential relevant agents, a flaw that has already been flagged by some working in that paradigm (Gleason, 2016; Lancy, 2012).

The notion that children can exercise agency has already been proven time after time by a myriad of researchers and scholars in different contexts and cultural settings (C. Christiansen, Utas, & Vigh, 2006; Grover, 2004; James, 2008; James & Hockey, 2007). The problem is that the idea of the child as an agentic creature became a mantra (Tisdall & Punch, 2012). However, not much thought has been put into reflecting how, why and under what conditions children's agency can emerge and be displayed. In other words, my claim is that it is time not to reduce our analysis to the question of whether children have or do not have the capacity to act and modify their own lives. As other fields of social research have done before, it is time for childhood studies to attempt to surpass simplistic and dichotomised analyses in order to engage with more complex questions about how agency can be expressed through nuanced dynamics which are also — as this thesis has revealed — highly dependent on external factors and sociomaterial elements. Therefore, agency is not to be considered as equal to unrestricted freedom, or to the ability to perform any action willed by the child. A more precise and sensitive definition seems to be that agency is, for these children, the

capacity to act amidst daily constraints and difficulties (Bordonaro, 2012; Bordonaro & Payne, 2012).

Sharing some of the same concerns as those expressed by critics of the new paradigm (Murriss, 2016; Prout, 2011; Ryan, 2012; Taylor, 2013; Tisdall & Punch, 2012), I felt that although the new paradigm was indeed a step forward in order to understand current childhoods, this analytical standpoint presented important shortcomings in giving an account of current childhoods and to fully understand my findings in the field, namely the complexities around the idea of children's agency. Considering the rich empirical material which was shared with me by medicated children and their peers, it became clear to me that children are endowed with agency. Agency expressed daily, as they manage to create their own private worlds which they mostly shielded away from adults' eyes. But also, agency expressed in the many ways by which they incorporate and intertwine with discourses, expectations, items and material objects surrounding them on a daily basis.

One of my main arguments throughout this thesis is that when it comes to children, agency is not only ambiguous but also an attribute that cannot be located exclusively as belonging to the child. It is something shared, emergent from the entanglements children establish with the stimulant medication, ambiguous agency (Bordonaro & Payne, 2012) inasmuch as the question about agency no longer relates to whether children can do things and impact on their own lives and the lives of those around them, but rather about how their actions are considered by others, and how they are evaluated in relation to their capacity to reflect and refract social consensus and follow expectations held by adults. In that sense, expectations such as 'paying attention', 'behaving correctly in the classroom', or 'getting better grades' become central for schools to consider the success of the pharmaceutical treatment. However, the medication can be successful in bolstering agency without living up to adult-centred expectations, which renders it necessary for researchers to somehow expand the notion of agency beyond what is considered as 'positive goals' such as becoming more autonomous, independent, and responsible (Asad, 2000; Mahmood, 2001).

In Chapter 5, I discussed this matter extensively. Contrary to popular expectations, children's subjectivities do not necessarily collapse when they come into contact with

psychostimulants. Even more, it seems to be the other way around: children can develop a renewed sense of agency via their interactions with medication. I find this to be particularly relevant, since it makes it necessary to question the long-standing humanism in childhood studies, opening what composes the very idea of the individual to multiple factors. This opens a new field of debate with which I have engaged in different sections of this thesis. Since neither the traditional nor current accounts in childhood studies seem to be able to grasp the subtleties and mutual determinations implied in the interactions between children's agency and the influential — even decisive — role played by other human and non-human actors in the classroom setting, I had to look elsewhere for inspiration. I borrowed ideas from a novel approach to childhood, one that was anticipated by the work of Alan Prout (Prout, 1996, 2005, 2011), and which has been sporadically continued by others (Kraftl, 2013; Lee & Motzkau, 2011; Ryan, 2012). Drawing from developments in other fields of social science, and with a special sensitivity towards relational materialism and posthumanism, these scholars have highlighted the shortcoming of oppositional dichotomies emanating from modernist social theory, arguing that in order to understand current childhoods a new model is required, one that can interrogate current societies and their unique and 'markedly disordered' composition, societies which are 'overflowing with phenomena that were mixed, hybrid, complex, impure, ambivalent, shifting, liquid, networked' (Prout, 2005. p. 61) and more.

Following up the opening of the borders of what 'composes' a child, different researchers have stressed the mutual determinations between children and a vast variety of elements. In particular, there has been some interest in the interconnections between children and technological gadgets (Mikkelsen & Christensen, 2009), and with biomedical devices (Prout, 1996). To my surprise, not much has been said from this approach about the topic of psychiatric medication, although some have already envisioned that this particular topic is something to be aware of when reflecting about crucial factors that might shape future childhoods (Prout, 2005). This is consistent with extensive research conducted in social sciences about the effects of new developments in genetics and biotechnology, which have granted novel forms of reflecting our own corporeal limits and their malleability, showing that what defines

our humanity cannot be reduced to mere biological predetermination any longer (Ortega, 2014; Rose, 2003; Rose & Abi-Rached, 2013; Vidal & Ortega, 2017).

So, if the limits of our own bodies — our bodily frontiers — do not work as a lock which encapsulates inside of us some of the central features defining our identity, why is it that social researchers of childhood mostly keep eluding the idea that agency can be something articulated in the interactions with other agents, instead of something ‘owned’, or ‘belonging to’ certain individuals? I believe that in part this idea persists because of the now common intuition that the limits of our own body are what defines our humanity. And in line with that, agency has to come from ‘within’ since, mostly, it is ultimately considered a human condition (Lee & Brown, 1994). However, and as I argued in this thesis, agency is not contained within the body, but developed, fostered, and/or emergent within sociomaterial life worlds, which render it possible for certain intentions and actions to be exercised, and for certain effects to be achieved.

Children participating in this study were a good example of the above mentioned. I discussed this matter in Chapter 5, arguing that two important things should be kept in mind when analysing how, in practice, the interactions between children, medication, and other sociomaterial elements took place. First, that once the medication enters the limits of the body it does not necessarily pose a threat to the child’s capacity for action. In line with reflections developed by Charis Thompson (Cussins, 1996; Thompson, 2005) I found that the pervasive humanist idea that individuals should be protected from biotechnology or biomedical by-products (in this case, pharmaceuticals) to protect their authenticity and agency is, to a great extent, an obstacle in the development of new approaches to understand current phenomena. As I related in Chapter 5, although children could be ‘objectified’ in biomedical discourses and pedagogical practices, from the moment of objectification the chance arose for medicated children to become something else. I refer to this chance for novelty as ‘potentiality’, while also arguing that this should always be considered as open-ended. Potentiality, in the sense that becoming an object of biomedical and pedagogical practices also granted medicated children the chance to purposely make use of those very same practices to achieve things of importance to themselves, to

strengthen their social connections, to build their private worlds, or — at times, but far from exclusively — to fulfil academic expectancies.

In that sense, fieldwork experience revealed that the use of medication did not go hand-in-hand with fulfilling adult expectations. Having the medication did not ensure better grades, or an improvement in school performance. The medication acted as a potentiality gateway, allowing novel things to happen. But it did not necessarily impose itself on the child. This means that medication does not come attached with an instruction guide foreseeing actions that will occur as an effect of its ingestion. Rather, it opens many pathways, and it largely rests upon the child — who is also influenced heavily by the sociomaterial and linguistic/symbolic context he or she inhabits — what path he or she will pursue. So, contrary to what is argued by the medicalization thesis, children have lots to say and do despite, and thanks to, having the medication.

The other important thing to keep in mind is that agency proved to be an attribute that, in practice, cannot be detached from context. It takes shape and reveals itself from within the limitations and constraints imposed by a certain setting. It is because children are to some extent, objectified, that they can become different. In the same spirit, it is because they are being required to take the medication that a new sense of agency can be developed.

Conceived like this, it becomes important to orientate future analyses not in the search for proofs of agency — as current childhood studies commonly do — but rather in attempting to unwrap how agency is knitted together in complex relations that are deeply entrenched in children's everyday lives. After all, as my fieldwork allowed me to conclude, the individual does not have to be thought of as subjugated by the presence of the medication. Constraints, in that sense, are not all oppressive and hence in need of being removed. They are also forces that can induce movement. They can provide the ground for something novel to happen and for potentiality to be accomplished. The context — and psychostimulant medication — provides opportunities and challenges, possibilities and constraints. Constraints that, in words of Emilie Gomart, can also be generous (2002), as I argued in Chapter 5.

Pharmaceutical entanglements

The aforementioned consideration of agency allows us to think differently about the interactions between children and stimulant medication. Instead of considering this relation as a clash of forces, or as a collision between two entities — one natural and in need of protection; the other human-made and menacing — attempting to overcome one another, it becomes possible to regard at this interaction from a different standpoint.

In this thesis, I claimed that in most cases I witnessed during my fieldwork, the coming together between the medicated child and stimulant medication took place in nuanced ways. Rather than opposing each other, they entangled together. And in these dynamics of mutual interactions and intertwining, both the medication and the child became something else, something different. They had an impact on each other, whose consequences unfolded in different ways. A few times the medication seemed to override the child's capacity to incorporate and make use of the potentiality of the medication. When that happened, it resembled as if the child became overloaded by bodily sensations induced by the drug. Children experiencing the aftermaths of this kind of interaction with stimulant medication reported feeling unwell, dizzy, and sometimes experiencing headaches and other kinds of unpleasant and uncomfortable bodily sensations and feelings. One of them also narrated feeling his own body differently, as if he were trapped inside a rigid frame with which he could not fully connect. Unquestionably, medication carries the potential for such outcomes. That is why — as I claimed in many different parts of this thesis — medication should not be taken lightly, and certain precautions should always be in order. As I argued in Chapter 1, stimulant medication is not the first line of treatment for ADHD, and neither should it be given freely without expert advice. In consequence of these precautions, in Chile it is expressly stated in guidelines that medication should be reconsidered every year as a safety measure and that ideally, it should always be part of a multimodal treatment (Ministerio de Salud, 2008). Sadly, this does not always happen, which in part allows us to understand the social resistance both to the medication and the diagnosis of ADHD during the last decades by part of the population.

However, most of the children participating in this research related to stimulant medication in a completely different way. Their entanglement was gentler, their interactions more nuanced, and the outcomes were utterly different from the ones described by those children that could not ‘connect’ soundly with the medication. I found this particularly interesting, and therefore greatly focused on this, as this is not what is usually encountered in social sciences’ accounts about the use of stimulant medication and, as I have come to reflect, was something that could only be made visible by moving away from the cliché, by opening to see these interactions with fresh eyes. The type of entanglement these children developed with the medication opened for them a new horizon of possibilities. Instead of fighting — and losing against — the effects induced by the medication, most children seemed able to play along with them. They recognised the bodily sensations prompted by the psychostimulants and were skilful enough to make use of the medication to secure different goals and aims. Considering these two different outcomes, I argued that different pharmaceutical entanglements could take place. My claim was that the kind of pharmaceutical entanglement each child develops depends on whether the medicated child was able or not to give the medication a purpose, while also depending on whether he or she was able to learn how to recognise and decode the signs and bodily sensations provoked by the medication in order to guide them to produce something more than just discomfort or a sense of strangeness.

I used the idea of ‘pharmaceutical entanglements’ to describe the potential matches between children and medication, while also highlighting the hybrid and complex composition of current childhoods. With this, I also attempted to provide an alternative to classic humanist notions of the child, too narrowly focused on considering children as closed entities. Thinking about pharmaceutical entanglements, I aimed to underscore how current compositions of the child are interwoven with sociomaterial elements. Even more, children reflect about themselves making use of these elements which are provided by their contexts. In that sense, their composition — what a child is, and what he or she can become — is highly plastic and malleable. In my case study, children made use of stimulant medication — and from practices related to their use — in order to become different, revealing different versions of themselves aided by the medication. Children actively used the sociomaterial

elements provided to them as building blocks in their own making-up and produced different ways of inhabiting their life worlds. Importantly, these building blocks are neither bland nor innocuous. They also have a say in the situation since they can impel or dispel actions, and produce modifications in the child and in the kind of interactions children prompt around them.

When arguing that context provides important keys to understanding how pharmaceutical entanglements take place, by 'context' I refer to more than just the material objects present in the classroom setting where I studied how the effects of the medication unfolded and were put into action by the medicated children. As I described in Chapter 4, medication is also attached to particular meanings which can be incorporated, refracted or rejected by the child, meanings which have social lives and trajectories which also impel and influence how these entanglements take place. As discussed earlier in this chapter, the possibilities to entangle with the medication are prone to be affected by children's and adults' expectations about the medication. And expectations, hopes and mistrust in relation to psychostimulant use can change in different times and places. But also, the kind of entanglement arising from this interaction relies on the individual purposes each child attaches to the medication, and to the whole experience of being objectified by the practices taking place in the classroom setting.

Pharmaceutical entanglements can be experienced as detrimental or beneficial. As described in Chapter 5, detrimental entanglements are experienced as unpleasant by the medicated child. Normally, a detrimental entanglement leads to a process of disengaging of the two actors — child and medication. Whether because side-effects of the pharmaceutical entanglement are reported by the medicated child after experiencing unpleasant and unwanted bodily sensations, or because someone else in the classroom noticed a subtle or pronounced shutdown of the medicated child's subjectivity, my experience in the classroom revealed that detrimental pharmaceutical entanglements are quickly brought to an end. In that sense, there is a fluent communication process that monitors that children do not get worse because of the medication.

For their part beneficial or virtuous pharmaceutical entanglements took place following different steps. It is important to clarify that 'beneficial' or 'detrimental' are not words being used to refer to academic performance or fulfilling school's academic expectations. In this context, detrimental means an entanglement that is experienced and reported by the child as self-defeating. On the other hand, a beneficial entanglement entails that children can make use of the medication to fulfil certain purposes, irrespective of their connection to academic expectations, or not. And mostly, these determinations were not connected to academic goals.

Following up the discussion mentioned earlier about agency as a shared property, virtuous entanglements were revealed to be linked to the child's capacity to put her agency to work in synchrony with those of the medication. If the actions and sensations induced by the medication are engaged by a child who actively attempts to perform the effects of the medication, something new happens. In theorising this idea I followed some of the findings of Howard Becker's classical study on drug use (1953). Just as the individuals he studied, the medicated children participating in this study who manage to enact virtuous entanglements intuitively followed some steps. They learnt that some actions were required so they and the medication could fit and work together. I extensively described these dynamics in Chapter 5. In a nutshell, children first must learn to recognise and interpret the effects induced by the psychostimulants. They must acknowledge that certain bodily sensations are a signal of something happening, that those sensations are a call for action. Secondly, children realised that the experience of these mental and bodily sensations must be steered to the pursuit of something. They should be given a purpose. Finally, as Scott Vrecko (2013) argues, emotional states must be encompassed and guided to fulfil and accomplish the goals defined.

As I observed, the introduction of the medication provides the opportunity for different elements to recombine, to articulate themselves in a different manner. But medication is not merely an excuse to produce a new choreography in which the individual is immersed, and according to which is (self)produced (Cussins, 1996). Psychostimulants produce something. They modify the bodily chemistry, enabling different things to happen. In that sense, as I argued through this thesis, the use of

stimulant medication cannot be reduced to a cause-effect causality. Rather, it should be understood as the injection of a certain degree of potentiality that at times can overwhelm the individual, but other times — most times according to my fieldwork experience — can be used to enact different dynamics. It can be put into action by an active child to produce something new: a re-articulation of past dynamics, or the emergence of different ones.

Conclusion

Conducting this research has been a wonderful — although exhausting — experience. During this 4-year journey, I have been lucky enough to explore and engage in debates reaching far beyond the modest scope this thesis initially had. In that sense, I came to realise that interest in this topic is something that exceeds my initial concern of exploring how children actively engage and make use of the medication in a variety of ways which cannot be pinned down and reduced to just one potential outcome. While sharing bits and pieces of my research in different academic settings, it was suggested to me how this topic can be a contribution to other debates taking place in different disciplines and by other academics and experts. Every time I got invited to share my experience I learned something new, as I was granted the possibility to look at the interconnections my research topic had with others from different perspectives. After a while, the audience I had in mind for my research opened up. It stopped being linked exclusively to those interested in Childhood Studies, as others pointed out its links with debates happening in fields related to the cultural and material determinants of mental health disorders, Science and Technology Studies, the Anthropology of Pharmaceuticals, the Medicalization debates, Critical Global Mental Health, Educational Studies, and the Sociology of the Elites, to name some. This has been a huge motivation, but also it has revealed different limitations of my research which I consider important to acknowledge in order to, hopefully, develop new inquiries in the near future.

One of the main limitations this research presents in its current form is the impossibility of generalising its findings. I stressed this point several times during the preceding chapters, arguing that to understand how stimulant medication and

children entangle together, it is crucial to understand the sociomaterial context where they meet. Realising the importance of the ecological niche is a key finding of this research, as it allows us to limit overarching arguments claiming the auto-effectiveness of stimulant medication, that is, the idea that it produces the exact same effects to everyone using it, despite where and why it is being used. Understanding how the effects of stimulant medication are enacted as a consequence of a choreographic arrangements bringing together multiple material and social elements allows us to fend off two opposite, yet extremely popular ideas. On the one hand, the social imagination that all stimulant medication can achieve is forcing medicated children to enter a state of numbness only useful for the purpose of imposing docility by teachers. On the other hand, it also allows to understand that stimulant medication is neither a 'magic bullet' nor its use implies academic achievement.

As argued, stimulant medication is something to be aware of, as it introduces into the scene a major transformative force that can be put into use virtuously, but that can also produce unwanted and unpleasant effects. That is why understanding the ecological niche becomes significant, as its role is important in understanding how medication is directed by the child — and other actors — in one direction or the other, as they have a say in this process. However, ecological niches are local. Therefore, how the children I described managed to introduce stimulant medication into their lives cannot be extended to become an overarching explanation of how stimulant medication works. The most I can do is to emphasise how special attention needs to be paid to the local embeddedness of the medication and of mental health diagnoses considering that not only were the effects of stimulant medication in part determined by the sociomaterial setting, but also that the rearing of children is profoundly affected by ideas and sensitivities animating the schools' educational projects. In that sense, what I encountered in my research regarding how stimulant medication is put into use by children is but one of many potential outcomes. Probably if expectations about children in these schools would have been different, the uses of the medication would be divergent as well. Because of this, I cannot make blunt or categorical claims such as arguing that the use of medication always fosters children's agency, or that its use always produces a regaining of control over their bodies and actions.

A second limitation to this research has to do with the socioeconomic background of the participants. When designing this thesis, I purposely aimed at conducting the research in schools where individuals came from families with a robust economic background. Children attending these schools are not the sons and daughters of the wealthiest families in Chile, but without any doubt they come from families where economic problems are not a constant threat. Having enough money to pay for private healthcare allows these families to search for different treatment options, to seek advice from more than one mental health professional, and even to experiment with alternative treatments to the pharmaceutical one in order to lessen or treat the symptoms commonly linked to having ADHD. My gambit was that families like these might have a different approach to the pharmaceutical treatment, one that could exhibit different traits considering that the use of stimulant medication was a choice, not an imposition. They have tried different modes of dealing with these behaviours — without much success — before turning to the medication, partially because they can afford to do so. And when the medication appears as a last resort, they have developed some understanding that no other thing they have tried has been successful enough to produce a real modification in the issues their children are experiencing at school and in other locations. So, in a way, and as was expressed during the interviews with medicated children, they are open to making the most of using the medication which has a direct impact on the emotional states linked to the process of producing virtuous entanglements. To put it differently, there is an openness to directing the bodily sensations produced by the medication in order to achieve different things, and there is a notion that the medication is not part of their lives just at random, but because there is something happening that could not be dealt with differently.

However, a completely different scenario is the one provided in other locations in Santiago — and probably in the world. Another setting is provided when stimulant medication becomes the only available tool provided by the public health system to treat children who exhibit symptoms linked to — but not exclusive to — ADHD, a diagnosis that apparently is being performed too quickly in Chile during the last decades, as I discuss in previous chapters. If one is to trust stories told by those researching such settings, it is a different world. My purpose was to explore how stimulant medication could reveal its effects when the conditions for this to happen

grant the possibility for the best potential outcomes. In fact, those are not the most common conditions under which the medication is being used. With overcrowded classrooms, scant help from mental health professionals, and little to no training in dealing with cases exhibiting learning difficulties or impairment, schools which most of the population attend are far from ideal. Therefore, my research can only claim what stimulant medication can do in relation to producing or bolstering children's agency, but it cannot be used to argue that this is what happens in most cases where expectations of its effects are different, sociomaterial resources are precarious, time is precious, and patience runs out more easily. Yet I want to emphasise that this does not authenticate the assumption that all the medication can produce is docility. I have produced in this thesis a different set of coordinates to study these entanglements, but they still need to be put into action in these ecological niches. I cannot claim what exactly could be found out of such research. But I am positive that it would be different from what I encountered in Mount Sinai and Bethlehem schools, just as I am sure that it is going to be far more nuanced than what classical sociological perspectives tend to argue.

A final limitation to this study has to do with the difficulties of transforming this research into a multi-sited ethnography for the sake of producing a more in-depth description of the practices taking place in classrooms. Notwithstanding that specialized literature tends to point at schools as the main actor in driving the consultation to a medical expert—which was also hinted by several participants in my research—it cannot be argued that this project could have benefited greatly by collecting data about medicated children in other sites (e.g. homes, clinics, parks, neighbourhoods, or any of the many different places where children can go to do extra-curricular activities), and by including other people beyond those present in the classroom setting (e.g. parents, brothers and sisters, friends from outside the school). Sadly, for strategic reasons which range from time to access, and other pragmatic considerations (Hammersley & Atkinson, 2007), I had to make a decision, which led me to choose to centre my analysis on the school setting. I do not regret this decision. However, I believe that data produced elsewhere could have provided a deeper understanding of how these pharmaceutical entanglements take shape in other places, and to what extent the coming together between children and medication can

vary according to the sociomaterial contexts. I believe for this to be a rich vein for researches to come.

The stories I shared during this thesis are just some of many others I encountered and experienced during my time in Mount Sinai and Bethlehem. I tried selecting those that more clearly revealed the complexities involved in something that has become so habitual that it risks turning into a commonplace — the medication of children. The purpose of my analysis was never to support the idea that medication was the best possible approach for handling children diagnosed with ADHD, but nor was my intention to agree without any hesitation with the somewhat naïve idea that all that these medications could do was detrimental for children. I emphatically tried to position myself outside this debate as I felt that, first of all, I needed to learn from the stories children shared with me. I needed to listen to their opinions and views, I needed to explore what happened in the classroom, and why. Only then I felt that I could make an informed argument of what I encountered.

My experience showed me that it is impossible to make blunt and general statements about the uses and effects of stimulant medication, as the classroom was not constituted and ruled by just one authority. For those who have not returned to a school's classroom since when they were children, it is important to remember that classrooms are messy and noisy. Several things happen simultaneously: children laugh, play, fight, cry, shout and learn, among many other things. The classroom is a setting where friendships are made, complicities are strengthened and new bonds emerge, where children are praised and encouraged to challenge themselves and reach their potential. But they are also a place where children are called to order, they are scolded, they fight, and where they can feel isolated and lonely. Classrooms are the place where children spend most of their time while growing up, and therefore it is critical to explore the dynamics taking place in them. It is, after all, children's lives that interest me the most, and if their lives can be somehow improved by thinking differently about their interactions with the medical apparatus, then maybe that is not a bad thing to be done. This is no easy task. However, it seems rather impossible to reconceptualise childhood without 'making a sizeable conceptual and difficult emotional shift' as Africca Taylor argues. But this shift, although challenging, might be for the best, as

there is 'more to gain than to lose if we shift from the seductive and natural Romantic coupling of childhood and nature (...) to the messy and complicated queer kin common worlds of childhood' (2013, p. 114). Whilst our current understanding of children seems to inexorably be moved towards scepticism in relation to what good may arise from their intermingling with pharmaceutical drugs, biomedical categories and, in general, with anything that could be considered as 'unnatural', in practice their lives are quite different. The common worlds children currently inhabit are filled to the brim with new technological devices, other non-human actors, hybrids between culture and nature, amongst other things. My effort was precisely to examine these, providing a foundation stone upon which new reflections could be elaborated in the future. Hopefully, this first step into understanding the complexity and multi-determined entanglement between children and stimulant medication will help to produce more informed, cautious, nuanced and local reflections. After all, to get a vivid image of what children's lives look like, they have to be considered in relation with what constrains and limits their daily existence, always keeping in mind how children make the best out of these situations to live and thrive.

Appendix

Information Documents and Consent Forms

1 : Invitation to participate for students

HOJA DE INFORMACION PARA ALUMNOS
Número de Referencia interno a KCL: SSHL/14/15-6



Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas

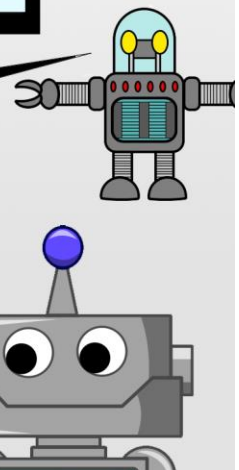
INTRO:

Estimado alumno:

La presente es una invitación para participar en el proyecto de investigación 'Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas', dirigido por Sebastián Rojas Navarro. La investigación es parte de mi proyecto doctoral, el cual es patrocinado por King's College London, y financiado por la Programa de Capital Humano Avanzado de la Comisión Nacional de Ciencia y Tecnología (CONICYT).

Queremos investigar como los niños que toman algunos remedios sienten que tomarlo influye en su día a día. También nos interesa averiguar cómo estos remedios influyen en la forma en que los niños se relacionan con sus compañeros, y cómo los compañeros y profesores interactúan con ellos.

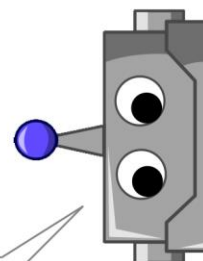
Para poder averiguar esto, un investigador va a ir al colegio entre Marzo y Junio de este año, a acompañarlos y estar con uds en la sala de clases, y tomara apuntes de la forma en que todos los niños se relacionan en la sala.



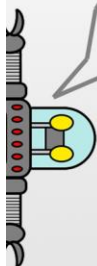
Es importante para nosotros averiguar cómo es la vida de los niños, y escuchar de parte de uds las historias que tengan que contarnos, las cosas que les llaman la atención y los motivos por los cuáles pasan ciertas cosas en los colegios.

Te queremos invitar a participar, y así poder escuchar lo que tú tienes que decir. Tu participación es voluntaria. Si no quieres participar, ¡está bien! No tienes que hacerlo. Sin embargo, nos encantaría poder escucharte ya que sentimos que muchas veces los adultos no se preocupan mucho de lo que los niños dicen, sienten o piensan.

Si decides participar, solamente tendrían que, a veces, hablar con el entrevistador para poder expresar tu punto de vista. Estas conversaciones se harán en la escuela, y trataremos de interrumpir lo menos posible las cosas que te gustan hacer.



Esperamos con esta investigación poder entender mejor cómo algunos remedios influyen en las salas de clases, entender cómo afectan a las experiencias que tienen los niños que los toman, para así poder pensar formas de mejorar el modo en que se llevan con los adultos del colegio y con sus compañeros. Queremos también tu ayuda para entender los efectos que tiene la medicación en la vida cotidiana, y poder reflexionar sobre problemas relacionados a esto según cuentan los profesionales que se dedican a investigar la vida de los niños.



Toda la información y las historias que nos cuenten serán anonimizada. Esto quiere decir que vamos a cambiar tu nombre, para que así nadie sepa que eres tú. Además, si en algún momento decides que no quieres seguir participando, puedes pedirle al investigador que no te pregunte más, o incluso que borre todo lo que le dijiste antes de su cuaderno de anotaciones.

Si ud siente que esta investigación te ha dañado de cualquier modo posible, o desea hacer una queja sobre la misma, pídeles a tus padres que le escriban al encargado de la investigación. Su nombre es Ilina Singh. Lamentablemente no habla español, por eso es mejor que si quieres escribirle, lo hagan tus papás. Los datos de Ilina son:

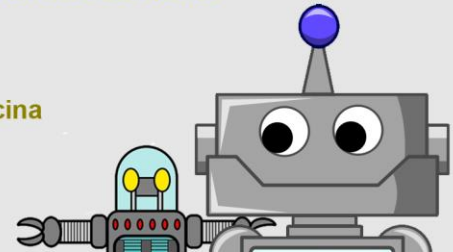
Dra. Ilina Singh,
Professor of Science, Ethics and Society; Director of Research; Department of
Social Science, Health and Medicine.
+44 207 848 7074
Ilina.singh@kcl.ac.uk



Si tienes dudas, o quieres saber más sobre la investigación ya que no estás seguro de querer participar, puedes acercarte al investigador y preguntarle, o puedes hablar con tus papás, ya que a ellos también se les explicará en detalle de que se trata esta investigación. También puedes decirle a tus papás que le escriban al investigador (o puedes hacerlo tú mismo) al correo electrónico sebastian.rojas_navarro@kcl.ac.uk

Muchas gracias por leer este documento, y por considerar ser parte de la investigación.

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Departamento de Ciencias Sociales, Salud y Medicina
King's College London



2: Following pages: Information Sheet for parents; pupils; school staff. Agreement to Participate for parents; pupils; school staff.

HOJA DE INFORMACION PARA PADRES

Número de Referencia interno a KCL: SSSL/14/15-6



Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas

Estimados padres:

La presente es una invitación para participar en el proyecto de investigación '**Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas**', dirigido por Sebastián Rojas Navarro. La investigación es parte de mi proyecto doctoral, el cual es patrocinado por King's College London, y financiado por la Programa de Capital Humano Avanzado de la Comisión Nacional de Ciencia y Tecnología (CONICYT).

El estudio tiene dos objetivos. Primero, entender de mejor forma como los niños que se encuentran consumiendo medicación como el metilfenidato experimentan su vida cotidiana, junto con explorar el rol de la medicación en sus experiencias cotidianas en la sala de clase. El segundo objetivo es explorar cómo las prácticas cotidianas llevadas a cabo en la sala están influenciadas o moldeadas por el hecho de que el niño esté tomando medicación. Para poder dar cuenta de estos objetivos, el investigador asistirá a algunas clases durante el periodo que transcurre entre Marzo y Junio del 2015, y tomará notas de las interacciones y relaciones entre los niños medicados y los otros actores que se encuentran dentro de la sala de clases.

Los contacto debido a que su hijo/a esta actualmente siendo tratado con algún tipo de psicoestimulante, o puede ser compañero/a de alumnos/as que están recibiendo tal tipo de medicación. Nos sería de gran ayuda si su hijo/a pudiese formar parte de esta investigación, la cual se extiende desde Marzo hasta Junio del 2015.

La participación es completamente voluntaria. No hay ninguna consecuencia por no querer tomar parte de la investigación. Si decide que su hijo/a no participe directamente, toda la información vinculada a su persona no será tomada en consideración para los propósitos de la investigación. Por su parte, si se le permite participar y si él o ella quiere hacerlo, no debe hacer nada especial, solamente actuar como normalmente lo hace en el colegio y, ocasionalmente, participar en conversaciones y entrevistas informales con el investigador respecto a temas relacionados a lo que acontece en la sala de clases. Estas conversaciones se realizaran en la escuela, y tienen como propósito entender cómo, en su opinión, los niños experimentan y reflexionan sobre las actividades cotidianas, y como comprenden algunas de las acciones y comportamientos que ocurren en las salas de clases.

Esperamos con esta investigación poder entender mejor el rol que juegan los psicoestimulantes en las salas de clases, entender cómo afectan a las experiencias que tienen los niños que lo consumen, y así poder pensar formas de mejorar el modo en que se vinculan con los profesionales del colegio y con sus compañeros; analizar los efectos concretos que tiene la medicación en la vida cotidiana, y poder reflexionar sobre problemas relacionados a estas temáticas en la literatura especializada, como el estigma social, discriminación, entre otros.

La información recopilada será anonimizada, es decir, se alteraran los nombres y locación de las observaciones. Además, si decide retirarse de la investigación en el proceso de la misma, toda la información producida por ud será eliminada. Esto puede efectuarse hasta que el investigador deje

de asistir al colegio, lo que ocurrirá a comienzos de Junio de 2015. Como ya se mencionó, la información será usada solamente para fines académicos.

En caso de que tenga más preguntas, o requiera mayor información acerca de la investigación, por favor contactarse conmigo al correo electrónico sebastian.rojas_navarro@kcl.ac.uk

Si ud siente que esta investigación le ha dañado de cualquier modo posible, o desea hacer una queja sobre la misma, puede contactar a mi supervisor en King's College London usando los siguientes detalles:

Dra. Iliana Singh,
Professor of Science, Ethics and Society; Director of Research; Department of Social Science,
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Iliana.singh@kcl.ac.uk
Muchas gracias por leer este documento informativo, y por considerar ser parte de la investigación.

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King's College London

HOJA DE INFORMACION PARA ALUMNOS

Número de Referencia interno a KCL: SSSL14/15-6



Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas

Estimado alumno:

La presente es una invitación para participar en el proyecto de investigación '**Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas**', dirigido por Sebastián Rojas Navarro. La investigación es parte de mi proyecto doctoral, el cual es patrocinado por King's College London, y financiado por la Programa de Capital Humano Avanzado de la Comisión Nacional de Ciencia y Tecnología (CONICYT).

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Para poder averiguar esto, un investigador va a ir al colegio entre marzo y junio de este año, a acompañarlos y estar con uds en la sala de clases, y tomara apuntes de la forma en que todos los niños se relacionan en la sala. Es importante para nosotros averiguar cómo es la vida de los niños, y escuchar de parte de uds las historias que tengan que contarnos, las cosas que les llaman la atención y los motivos por los cuáles pasan ciertas cosas en los colegios.

Te queremos invitar a participar, y así poder escuchar lo que tú tienes que decir. Tu participación es voluntaria. Si no quieres participar, ¡está bien! No tienes que hacerlo. Sin embargo, nos encantaría poder escucharte ya que sentimos que muchas veces los adultos no se preocupan mucho de lo que los niños dicen, sienten o piensan.

Si decides participar, solamente tendrían que, a veces, hablar con el entrevistador para poder expresar tu punto de vista. Estas conversaciones se harán en la escuela, y trataremos de interrumpir lo menos posible las cosas que te gustan hacer.

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Toda la información y las historias que nos cuenten serán anonimizada. Esto quiere decir que vamos a cambiar tu nombre, para que así nadie sepa que eres tú. Además, si en algún momento decides que no quieres seguir participando, puedes pedirle al investigador que no te pregunté más, o incluso que borre todo lo que le dijiste antes de su cuaderno de anotaciones.

Si tienes dudas, o quieres saber más sobre la investigación ya que no estás seguro de querer participar, puedes acercarte al investigador y preguntarle, o puedes hablar con tus papás, ya que a ellos también se les explicará en detalle de que se trata esta investigación. También puedes decirle

a tus papás que le escriban al investigador (o puedes hacerlo tú mismo) al correo electrónico sebastian.rojas_navarro@kcl.ac.uk

Si ud siente que esta investigación te ha dañado de cualquier modo posible, o desea hacer una queja sobre la misma, pídeles a tus padres que le escriban al encargado de la investigación. Su nombre es Ilna Singh. Lamentablemente no habla español, por eso es mejor que si quieres escribirle, lo hagan tus papás. Los datos de Ilna son:

Dra. Ilna Singh,
Professor of Science, Ethics and Society; Director of Research; Department of Social Science,
Health and Medicine.
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ilna.singh@kcl.ac.uk

Muchas gracias por leer este documento, y por considerar ser parte de la investigación.

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Departamento de Ciencias Sociales, Salud y Medicina
King's College London

HOJA DE INFORMACION PARA PERSONAL DEL COLEGIO

Número de Referencia interno a KCL: SSHL/14/15-6



Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas

Estimado funcionario:

La presente es una invitación para participar en el proyecto de investigación '**Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas**', dirigido por Sebastián Rojas Navarro. La investigación es parte de mi proyecto doctoral, el cual es patrocinado por King's College London, y financiado por la Programa de Capital Humano Avanzado de la Comisión Nacional de Ciencia y Tecnología (CONICYT).

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Ud ha sido contactado debido a que se nos informó que actualmente se encuentra enseñando o interactuando en quinto básico con alumnos que consumen psicoestimulantes. Agradeceríamos enormemente si aceptase compartir sus opiniones, puntos de vista y experiencias en relación con el tema de la investigación durante el tiempo en que esta se lleva a cabo.

Su participación es completamente voluntaria. No hay ninguna consecuencia por no querer tomar parte de la investigación. Si decide no hacerlo, toda la información vinculada a su persona no será tomada en consideración para los propósitos de la investigación. Por su parte, si decide participar, no debe hacer nada especial, solamente actuar como normalmente lo hace en el colegio y, ocasionalmente, participar en conversaciones y entrevistas informales con el investigador respecto a temas relacionados a lo que acontece en la sala de clases. Estas conversaciones se realizarán en la escuela, y tienen como propósito entender cómo, en su opinión, los niños experimentan y reflexionan sobre las actividades cotidianas, y como comprenden algunas de las acciones y comportamientos que ocurren en las salas de clases.

Toda la información recolectada será confidencial, y el contenido no será revelado hasta que la información y el entrevistado sean anonimizados. Una vez hecho esto, partes del contenido pueden ser utilizadas para propósitos académicos, siempre respetando el anonimato de los participantes.

Esperamos con esta investigación poder entender mejor el rol que juegan los psicoestimulantes en las salas de clases, entender como afectan a las experiencias que tienen los niños que lo consumen, y así poder pensar formas de mejorar el modo en que se vinculan con los profesionales del colegio y con sus compañeros; analizar los efectos concretos que tiene la medicación en la vida cotidiana, y poder reflexionar sobre problemas relacionados a estas temáticas en la literatura especializada, como el estigma social, discriminación, entre otros.

La información recopilada será anonimizada, es decir, se alteraran los nombres y locación de las observaciones. Además, si decide retirarse de la investigación en el proceso de la misma, toda la información producida por ud será eliminada. Esto puede efectuarse hasta que el investigador deje de asistir al colegio, lo que ocurrirá a comienzos de Junio de 2015. Como ya se mencionó, la información será usada solamente para fines académicos.

En caso de que tenga más preguntas, o requiera mayor información acerca de la investigación, por favor contactarse conmigo al correo electrónico sebastian.rojas_navarro@kcl.ac.uk. Si ud siente que esta investigación le ha dañado de cualquier modo posible, o desea hacer una queja sobre la misma, puede contactar a mi supervisor en King's College London usando los siguientes detalles:

Dra. Iliana Singh,
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Muchas gracias por leer este documento informativo, y por considerar ser parte de la investigación.

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Departamento de Ciencias Sociales, Salud y Medicina
King's College London

CONSENTIMIENTO INFORMADO PARA PADRES

Por favor complete el consentimiento informado después de haber leído la hoja de información, o de haber escuchado una explicación de la investigación de parte del investigador



Nombre de la investigación: Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas.

Número de referencia, comité de ética, King's College London: SSHL/14/15-6

Gracias por permitir a su hijo/a participar de la investigación. Si tiene cualquier duda con respecto a la hoja de información o a la explicación dada por el investigador, por favor contacte al mismo antes de decidir participar o no. Se le dará una copia de este documento para que pueda guardar y usar en caso de dudas.

Marque
con ticket
o sus
iniciales

☐

Confirmando que entiendo que al poner un ticket o mis iniciales en cada casilla, estoy aceptando lo descrito a la izquierda de la casilla marcada. Entiendo que si no marco la casilla, eso significa que NO doy mi consentimiento para esa parte del estudio. Entiendo que si no marco ninguna casilla puedo ser dejado fuera de la investigación.

Marque
con ticket
o sus
iniciales

1. Confirmando que leí y entendí la hoja de información. He tenido la oportunidad de reflexionar respecto a la información allí expresada. De haber preguntado algo, me ha sido dada una respuesta satisfactoria.
2. Entiendo que la participación es voluntaria, y que mi hijo/a es libre de retirarse en cualquier momento, sin estar obligado a explicar sus motivos. Además, entiendo que puedo pedir que la información relacionada a mi hijo/a sea retirada de la investigación hasta el día 23 de junio del 2015
3. Consiento a que se use la información para los propósitos explicados en la hoja de información.
4. Consiento que mi hijo/a sea parte de las observaciones en la sala de clases, que se llevarán a cabo entre marzo y junio de 2015.
5. Entiendo que su información puede ser revisada por personas de King's College London, para propósitos de monitoreo del desarrollo de la investigación.

☐☐☐☐☐

6. Entiendo que su confidencialidad y anonimato será mantenido siempre, imposibilitando que sea reconocido en cualquier publicación académica futura. ☐
7. Estoy de acuerdo que el investigador pueda revisar sus antecedentes académicos para propósitos de esta investigación. ☐
8. Doy permiso al investigador para usar la información para motivos académicos en el futuro, en cuyo caso se mantendrá siempre un total anonimato de la persona de mi hijo/a, y se cumplirán los estándares éticos acordes, siendo la publicación revisada por un panel de expertos ☐
9. Entiendo que de esta investigación se realizará un reporte, y deseo que me hagan llegar una copia del mismo cuando esté listo. ☐

Nombre del participante

Firma:

CONSENTIMIENTO INFORMADO PARA ALUMNOS

Por favor complete el consentimiento informado después de haber leído la hoja de información, o de haber escuchado una explicación de la investigación de parte del investigador



Nombre de la investigación: Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas.

Número de referencia, comité de ética, King's College London: SSHL/14/15-6

Gracias por decidir participar de la investigación. Si tiene cualquier duda con respecto a la hoja de información o a la explicación dada por el investigador, por favor contacte al mismo antes de decidir participar o no. Se le dará una copia de este documento para que pueda guardar y usar en caso de dudas.

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Nombre del participante

Firma

CONSENTIMIENTO INFORMADO PARA FUNCIONARIOS DEL COLEGIO

Por favor complete el consentimiento informado después de haber leído la hoja de información, o de haber escuchado una explicación de la investigación de parte del investigador



Nombre de la investigación: Investigando a niños medicados a través de sus prácticas cotidianas: explorando los efectos de los psicoestimulantes en las salas chilenas.

Número de referencia, comité de ética, King's College London: SSHL/14/15-6

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Nombre del participante

Firma:

References

- Abarzúa, M. and González, M. (2012). Salud mental infanto-juvenil como problemática pública. *Revista de Psicología*, **16**(2): 79–95. <https://doi.org/10.5354/0719-0581.2007.18523>
- Abi-Rached, J. M. and Rose, N. (2010). The birth of the neuromolecular gaze. *History of the Human Sciences*, **23**(1): 11–36. <https://doi.org/10.1177/0952695109352407>
- ACES. (2012). “ACES Chile: Propuesta para la educación que queremos.” Retrieved 12 August, 2014, from <http://www.movilizatechile.cl/2012/05/aces-chile-propuesta-para-la-educacion-que-queremos/>
- Advokat, C. and Scheithauer, M. (2013). Attention-deficit hyperactivity disorder (ADHD) stimulant medications as cognitive enhancers. *Frontiers in Neuroscience*, **7**:1-8. <https://doi.org/10.3389/fnins.2013.00082>
- Aguilar, O. (2011). Dinero, educación y moral: el cierre social de la elite tradicional chilena. In *Notables, tecnócratas y mandarines. Elementos de sociología de las elites en Chile (1990-2010)*. A. Joignant & P. Guell (Eds.). Santiago, Ediciones UDP.
- Alvarez, C. (2008). La etnografía como modelo de investigación en educación. *GAZETA DE ANTROPOLOGÍA*, **24**(1). <http://hdl.handle.net/10481/6998>
- Alvarez, C. (2011). El interés de la etnografía escolar en la investigación educativa. *Estudios Pedagógicos*, **37**(2): 267–279.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (4th edition). Washington, DC, American Psychiatric Association.
- American Psychiatric Association and DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C., American Psychiatric Association.
- Araya, O. (1986, July 1). *Los niños y el psiquiatra*. Revista YA.
- Araya, O. (1987a, March 17). *Enredos infantiles*. Revista YA.
- Araya, O. (1987b, April 7). *El niño eléctrico*. Revista YA.
- Ariès, P. (1975). *L'enfant et la vie familiale sous l'Ancien Régime*. Paris, Éditions du Seuil.
- Armstrong, D. (1983). *Political Anatomy of the Body: Medical Knowledge in Britain in the*

Twentieth Century. Cambridge, England; New York, Cambridge University Press.

Arruda-Leal, A. (2011). The subjectivity experience as condition and effect of psychological knowledge and practices: Subjectivity production and psychology. *Estudios de Psicología*, **32**(3): 359–374. <https://doi.org/10.1174/021093911797898529>

Asad, T. (2000). Agency and pain: An exploration. *Culture and Religion*, **1**(1): 29–60. <https://doi.org/10.1080/01438300008567139>

Barkley, R. (2005). *Attention-Deficit Hyperactivity Disorder, Third Edition: A Handbook for Diagnosis and Treatment* (3rd edition). New York, The Guilford Press.

Barkley, R. A. (2002). International consensus statement on ADHD. January 2002. *Clinical Child and Family Psychology Review* **5**(2): 89–111.

Becerra, M. (2013a). *La industria farmacéutica y el Ritalín*. El Ciudadano. Available: <http://www.elciudadano.cl/wp-content/plugins/lightbox-pop/iframe.php> [Accessed 24 February, 2014]

Becerra, M. (2013b). *Ritalín: Una sociedad que droga a sus niños*. El Ciudadano. Available: <http://www.elciudadano.cl/wp-content/plugins/lightbox-pop/iframe.php> [Accessed 24 February, 2014]

Becker, H. S. (1953). Becoming a Marihuana User. *American Journal of Sociology*, **59**(3): 235–242.

Béhague, D. P. and Lézé, S. (2015). Shaping the modern child: Genealogies and ethnographies of developmental science. *Social Science & Medicine*, **143**: 249–254. <https://doi.org/10.1016/j.socscimed.2015.09.018>

Behrouzan, O. (2016). *Prozak Diaries*. Stanford, Stanford University Press.

Bell, S. E. and Figert, A. E. (2012). Medicalization and pharmaceuticalization at the intersections: Looking backward, sideways and forward. *Social Science & Medicine*, **75**(5): 775–783. <https://doi.org/10.1016/j.socscimed.2012.04.002>

Bell, S. E. and Figert, A. E. (2015). *Moving sideways and forging ahead. Reimagining “-Izations” in the Twenty-First Century*. In *Reimagining (Bio)Medicalization, Pharmaceuticals and Genetics. Old Critiques and New Engagements* (1st Edition). S. E. Bell & A. E. Figert (Eds.). Abingdon, Oxon;

New York, Routledge.

Bellei, C., Cabalin, C. and Orellana, V. (2014). The 2011 Chilean student movement against neoliberal educational policies. *Studies in Higher Education*, **39**(3): 426–440.

<https://doi.org/10.1080/03075079.2014.896179>

Bemme, D. and D'souza, N. (2012). "Global Mental Health and its Discontents". Retrieved October 6, 2017, from <http://somatosphere.net/2012/07/global-mental-health-and-its-discontents.html>

Bendelow, G., Carpenter, M., Vautier, C. and Williams, S. (2012). *Gender, Health and Healing: The Public/Private Divide*. London; New York, Routledge.

Berg, M. and Mol, A. (1998). *Differences in medicine: unraveling practices, techniques, and bodies*. Durham, N.C., Duke University Press.

Biehl, J. G., Good, B. and Kleinman, A. (2007). *Subjectivity: ethnographic investigations*. Berkeley, University of California Press.

Biehl, J. and Locke, P. (2010). Deleuze and the Anthropology of Becoming. *Current Anthropology*, **51**(3): 317–351. <https://doi.org/10.1086/651466>

Bordonaro, L. I. (2012). Agency does not mean freedom. Cape Verdean street children and the politics of children's agency. *Children's Geographies*, **10**(4): 413–426.

<https://doi.org/10.1080/14733285.2012.726068>

Bordonaro, L. I., & Payne, R. (2012). Ambiguous agency: critical perspectives on social interventions with children and youth in Africa. *Children's Geographies*, **10**(4): 365–372.

<https://doi.org/10.1080/14733285.2012.726065>

Bourdieu, P. (2010). *Distinction* (1st edition). Abingdon, Oxon, Routledge.

Bourdieu, P. and Passeron, P. (1964). *Les heritiers: Les étudiants et la culture*. Paris, Les Editions de Minuit.

Brady, G. (2014). Children and ADHD: seeking control within the constraints of diagnosis. *Children & Society*, **28**(3), 218–230. <https://doi.org/10.1111/chso.12069>

Bray, L., Kirk, S. and Callery, P. (2013). *Developing biographies: the experiences of children*,

young people and their parents of living with a long-term condition. *Sociology of Health & Illness*, **36**(6): 823-839. <https://doi.org/10.1111/1467-9566.12110>

Breggin, P. R. (2001). *Talking back to Ritalin: what doctors aren't telling you about stimulants and ADHD*. Cambridge, Mass., Perseus Pub.

Burman, E. (2007). *Developments: Child, Image, Nation*. New York, Taylor & Francis.

Burman, E. (2008). *Deconstructing Developmental Psychology* (2nd Edition). London; New York, Routledge.

Bush, P. J., Trakas D., Sanz, E., Wirsing, R., Vaskilampi, T. and Prout, A. (Eds.). (1996). *Children, Medicines, and Culture* (1st edition). New York, Pharmaceutical Products Press/Haworth Press.

Buttinghausen G, V., Cruz F, J., Elizalde R, L., Tapia D, D., Figueroa J, F. and Huidobro M, A. (2011). Frecuencia de administración de psicoestimulantes en escolares de primero a sexto básico en Talca. *Revista Chilena de Neuro-Psiquiatría*, **49**(3): 258–264. <https://doi.org/10.4067/S0717-92272011000300006>

Camargo Brito, R. (2008). 'El carácter traumático del consenso en torno al "Modelo Chileno": una investigación sobre la elite política democrática post-Pinochet', *Nuevo Mundo Mundos Nuevos*. [Online] Conference, Santiago, 5-6 September, 2007. Placed online 14 January, 2008. <https://doi.org/10.4000/nuevomundo.11502> [Accessed: 6 November, 2017]

Charach, A., Skyba, A., Cook, L. and Antle, B. J. (2006). Using Stimulant Medication for Children with ADHD: What Do Parents Say? A Brief Report. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, **15**(2): 75–83.

Charpentier, D. (2013). *¿Por qué casi no hay niños franceses hiperactivos o con déficit atencional?* [Online] Available from: <http://www.biobiochile.cl/2013/06/03/por-que-casi-no-hay-ninos-franceses-hiperactivos-o-con-deficit-atencional.shtml> [Accessed: June 25, 2014]

Christensen, P. (2000). Childhood and the Cultural Constitution of Vulnerable Bodies. In *The body, childhood and society*. A. Prout (Ed.) London, Macmillan.

Christensen, P. and James, A. (2008). *Research with children: perspectives and practices*. New York, NY, Routledge.

Christiansen, A. (2013). *Estudio dice que fármacos no ayudan a niños con déficit atencional*.

[Online] La Tercera. Available from:

<http://www.latercera.com/noticia/tendencias/2013/02/659-508787-9-estudio-dice-que-farmacos-no-ayudan-a-ninos-con-deficit-atencional.shtml> [Accessed: June 25, 2014]

Christiansen, C., Utas, M. and Vigh, H. E. (Eds.). (2006). *Navigating Youth, Generating Adulthood: Social Becoming in an African Context*. Uppsala, Nordic Africa Institute.

Clarke, A. E., Mamo, L., Fosket, J. R., Fishman, J. R. and Shim, J. K. (2010). *Biomedicalization: Technoscience, Health, and Illness in the U.S.* (1st edition). Durham, NC, Duke University Press Books.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R. and Fishman, J. R. (2003). Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine. *American Sociological Review*, **68**(2): 161–194. <https://doi.org/10.2307/1519765>

Claro, S. (2011). *Clima escolar y desarrollo integral de niñas y niños Historia, aprendizajes y proyecciones de una experiencia*. Santiago, RIL editores.

Colegio de Psicólogos de Chile. [no date]. “Código de Ética Profesional | Colegio de Psicólogos de Chile”. Retrieved 16 January, 2015, from http://colegiopsicologos.cl/web_cpc/quienes-somos/codigo-de-etica-profesional/

Cohen, E. F. and Morley, C. P. (2009). Children, ADHD, and Citizenship. *Journal of Medicine and Philosophy*, **34**(2): 155–180. <https://doi.org/10.1093/jmp/jhp013>

Conrad, P. (1976). *Identifying Hyperactive Children: The Medicalization of Deviant Behavior*. Lexington, MA., D.C. Heath.

Conrad, P. (1979). Types of medical social control. *Sociology of Health & Illness*, **1**(1): 1–11. <https://doi.org/10.1111/j.1467-9566.1979.tb00175.x>

Conrad, P. (1992). Medicalization and Social Control. *Annual Review of Sociology*, **18**(1): 209–232. <https://doi.org/10.1146/annurev.so.18.080192.001233>

Conrad, P. (2005). The Shifting Engines of Medicalization. *Journal of Health and Social Behavior*, **46**(1): 3–14. <https://doi.org/10.1177/002214650504600102>

Conrad, P. (2006). *Identifying Hyperactive Children: The Medicalization of Deviant Behavior (Ashgate Classics in Sociology)* (Expanded edition). Abingdon, Oxon; New York, Ashgate Pub Co.

- Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (1st edition). Baltimore, Johns Hopkins University Press.
- Conrad, P. (2015). Foreword. In *Reimagining (Bio)Medicalization, Pharmaceuticals and Genetics. Old Critiques and New Engagements* (1st Edition). S. E. Bell and A. E. Figert (Eds.). New York, Routledge.
- Conrad, P. and Schneider, J. W. (1992). *Deviance and medicalization: from badness to sickness: with a new afterword by the authors*. Philadelphia, Temple University Press.
- Cussins, C. (1996). Ontological Choreography: Agency through Objectification in Infertility Clinics. *Social Studies of Science*, **26**(3): 575–610. <https://doi.org/10.1177/030631296026003004>
- Cuthbertson, C. A. (2015). *Pharmaceutical technologies and the management of biological citizens in Chile*. In *Reimagining (Bio)Medicalization, Pharmaceuticals and Genetics. Old Critiques and New Engagements*. S. E. Bell & A. E. Figert (Eds.) New York, Routledge.
- Cypher, J. (2004). Is Chile a neoliberal success? *Dollars and Sense. Real World Economics*, September **255** [no pages].
- Davis, J. E. (2006). How medicalization lost its way. *Society*, **43**(6): 51–56. <https://doi.org/10.1007/BF02698486>
- de la Barra, F. E., Vicente, B., Saldivia, S. and Melipillan, R. (2013). Epidemiology of ADHD in Chilean children and adolescents. *Attention Deficit and Hyperactivity Disorders*, **5**(1): 1–8. <https://doi.org/10.1007/s12402-012-0090-6>
- Delamont, S. (1990). *Interaction in the Classroom* (2nd revised edition). London; New York, Routledge.
- Despret. (2008). The Becomings of Subjectivity in Animal Worlds. *Subjectivity*, **23**:123–139.
- Donzelot, J. (1997). *The policing of families*. Baltimore, Johns Hopkins University Press.
- Du Gay, P. (2008). *Organizing conduct, making up people*. In *Conduct: Sociology and Social Worlds*. L. McFall, P. Du Gay, and S. Carter (Eds.) Manchester, Manchester University Press.
- Ecks, S. (2013). *Eating Drugs: Psychopharmaceutical Pluralism in India* (1st edition). New York; London, NYU Press.

- Educarchile. (n.d). *“Ritalín en la sala de clases”*. Retrieved 10 August, 2014, from <http://www.educarchile.cl/ech/pro/app/detalle?id=106430>
- [no author]. (2016, December 27). *Ranking: Los 100 colegios del país que promediaron los mejores puntajes en la PSU* [Online]. Emol.com. Available from <http://www.emol.com/noticias/Nacional/2016/12/27/837326/Ranking-Los-100-colegios-del-pais-que-promediaron-los-mejores-puntajes-en-la-PSU.html> [Accessed: 13 March, 2017]
- Elacqua, G. (2012). The impact of school choice and public policy on segregation: Evidence from Chile. *International Journal of Educational Development*, **32**(3): 444–453. <https://doi.org/10.1016/j.ijedudev.2011.08.003>
- Emirbayer, M. and Mische, A. (1998). What Is Agency? *American Journal of Sociology*, **103**(4): 962–1023. <https://doi.org/10.1086/231294>
- Espinoza, V. (2010). Redes de poder y sociabilidad en la élite política chilena: Los parlamentarios 1990-2005. *Polis (Santiago)*, **9**(26): 251–286. <https://doi.org/10.4067/S0718-65682010000200013>
- Etkin, N. L. (1988). *Cultural constructions of efficacy*. In *The context of medicines in developing countries: Studies in pharmaceutical anthropology*. S. van der Geest and S. R. Whyte (Eds.) Kluwer Academic Publishers.
- Fassin, D. (2011). *This is not medicalization*. In *Drugs and culture: knowledge, consumption and policy* (1st edition). G. Hunt, M. Milhet and H. Bergeron (Eds.). Burlington, V.T., Ashgate.
- Ferreira, A. A. L. (2015). Na contramão da História: um estudo das estratégias de pesquisa psicológicas à luz da TAR. *Estudos E Pesquisas Em Psicologia*, **15**(SPE): 1224–1237.
- Ferreira, A. A. L., Pereira, N. B. and Figueredo, B. F. (2014). Técnicas de si e clínica psi: um campo de estudos etnográficos / Techniques of the self and clinical psychology: a field for ethnographic studies. *Revista Polis e Psique*, **4**(3): 80–99.
- Fielding, N. (2006). *Ethnographic Interviewing*. In *The SAGE Dictionary of Social Research Methods*. [Online]. London, SAGE Publications, Ltd. Available from <http://srmo.sagepub.com/view/the-sage-dictionary-of-social-research-methods/n69.xml>
- Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977* (1st

American edition). New York, Random House USA Inc.

Foucault, M. (1982). The Subject and Power. *Critical Inquiry*, **8**(4): 777–795.

Foucault, M. (1991). *Discipline and Punish: The Birth of the Prison* (New edition). London, Penguin.

Fraser, D. S., Valentine, K. and Roberts, C. (2009). Living Drugs. *Science as Culture*, **18**(2): 123–131. <https://doi.org/10.1080/09505430902885441>

Frazzetto, G., Keenan, S. and Singh, I. (2007). “I Bambini e le Droghe”: The Right to Ritalin vs the Right to Childhood in Italy. *BioSocieties*, **2**(4): 393–412.
<https://doi.org/10.1017/S1745855207005844>

Freidson, E. (2007). *Professional dominance: the social structure of medical care*. New Brunswick, N.J., Aldine Transaction.

Frigerio, A., Montali, L. and Fine, M. (2013). Attention deficit/hyperactivity disorder blame game: A study on the positioning of professionals, teachers and parents. *Health*: **17**(6): 584–604.
<https://doi.org/10.1177/1363459312472083>

Gad, C. and Jensen, C. B. (2014). The promises of practice. *The Sociological Review*, **62**(4): 698–718. <https://doi.org/10.1111/1467-954X.12200>

Gallacher, L.-A. and Gallagher, M. (2008). Methodological Immaturity in Childhood Research? Thinking through ‘participatory methods’. *Childhood*, **15**(4): 499–516.
<https://doi.org/10.1177/0907568208091672>

Galvez, K. (1995a). *El deficit atencional madura con y sin Ritalin*. Revista YA.

Galvez, K. (1995b). *Mi vida es un drama total*. Revista YA.

Garretón, M. A. (2004). “De la transición a los problemas de calidad en la democracia chilena”. Retrieved 12 January, 2015, from <http://www.redalyc.org/resumen.oa?id=64504209>

Geertz, C. (2010). *The Interpretation of Cultures* (New edition). London, Fontana Press.

Gibbon, S. and Novas, C. (Eds.). (2007). *Biosocialities, Genetics and the Social Sciences: Making Biologies and Identities* (New edition). London; New York, Routledge.

Gleason, M. (2016). Avoiding the agency trap: caveats for historians of children, youth, and

education. *History of Education*, **45**(4): 446–459.

<https://doi.org/10.1080/0046760X.2016.1177121>

Gomart, E. (2002). Towards generous constraint: freedom and coercion in a French addiction treatment. *Sociology of Health & Illness*, **24**(5): 517–549. <https://doi.org/10.1111/1467-9566.00307>

Gomart, E. (2004). Surprised by Methadone: in Praise of Drug Substitution Treatment in a French Clinic. *Body & Society*, **10**(2–3): 85–110. <https://doi.org/10.1177/1357034X04042937>

Gordon, T., Holland, J. and Lahelma, E. (2007). *Ethnographic research in educational settings*. In *Handbook of Ethnography*. P. Atkinson, A. Coffey, S. Delamont and L. Lofland (Eds.). London; Thousand Oaks, SAGE Publications Ltd.

Graf, W. D. and Singh, I. (2015). Can Guidelines Help Reduce the Medicalization of Early Childhood? *The Journal of Pediatrics*, **166**(6): 1344–1346. <https://doi.org/10.1016/j.jpeds.2015.03.049>

Greene, J. A. (2008). *Prescribing by Numbers: Drugs and the Definition of Disease* (1st edition). Baltimore, MD, Johns Hopkins University Press.

Grover, S. (2004). Why Won't They Listen to Us? On Giving Power and Voice to Children Participating in Social Research. *Childhood*, **11**(1): 81–93. <https://doi.org/10.1177/0907568204040186>

Hacking, I. (2000). *The Social Construction of What?* Cambridge, Mass., Harvard University Press.

Hacking, I. (2004). *Historical Ontology*. Cambridge, Mass., Harvard University Press.

Hacking, I. (2007). *Kinds of People: Moving Targets*. In *Proceedings of the British Academy, Volume 151, 2006 Lectures*. P. J. Marshall (Ed.). [Online]. British Academy. Available from <http://www.britishacademypublications.com/view/10.5871/bacad/9780197264249.001.0001/upso-9780197264249-chapter-10>

Hallett, C. and Prout, A. (Eds.). (2003). *Hearing the Voices of Children: Social Policy for a New Century* (1st edition). London; New York, Routledge.

Harwood, V. (2005). *Diagnosing “Disorderly” Children: A critique of behaviour disorder discourses*. London; New York, Routledge.

Hawthorne, S. C. C. (2010). Institutionalized Intolerance of ADHD: Sources and Consequences. *Hypatia*, **25**(3): 504–526. <https://doi.org/10.1111/j.1527-2001.2010.01113.x>

Hendrick, H. (1997). *Constructions and reconstructions of British childhood: an interpretative survey, 1800 to the present*. In *Constructing and reconstructing childhood: contemporary issues in the sociological study of childhood*. A. James and A. Prout (Eds). London; Washington, D.C.: Falmer Press.

Hsieh, C.-T. and Urquiola, M. (2003). *When Schools Compete, How Do They Compete? An Assessment of Chile's Nationwide School Voucher Program* (Working Paper No. 10008). National Bureau of Economic Research. Available from: <http://www.nber.org/papers/w10008>

Hunleth, J. (2011). Beyond on or with: Questioning power dynamics and knowledge production in “child-oriented” research methodology. *Childhood*, **18**(1): 81–93. <https://doi.org/10.1177/0907568210371234>

Illich, I. (1976). *Limits to Medicine: Medical Nemesis - The Expropriation of Health* (New edition). London, Marion Boyars.

Instituto Nacional de Estadística. (2017). “*Ingresos y Gastos | Instituto Nacional de Estadísticas | INE 2017*”. Retrieved 17 March, 2017, from http://www.ine.cl/canales/chile_estadistico/familias/ingresos_gastos.php

International Narcotic Control Board. (2013). “*Psychotropic Substances. Statistics for 2012. Assessments of Annual Medical and Scientific Requirements*”. United Nations. Retrieved 18 June, 2014, from http://www.incb.org/documents/Psychotropics/technical-publications/2013/en/Tech_pub_2013.pdf

Jain, L. (2013). *Malignant: How Cancer Becomes Us*. Berkeley, University of California Press.

James, A. (2008). *European Childhoods: Cultures, Politics and Childhoods in Europe*. Basingstoke, Palgrave MacMillan.

James, A. and Hockey, J. L. (2007). *Embodying health identities*. Houndmills, Basingstoke, Hampshire; New York, Palgrave Macmillan.

James, A. and James, A. (2004). *Constructing Childhood: Theory, Policy and Social Practice*. Houndmills, Basingstoke, Hampshire; New York, Palgrave Macmillan.

- James, A. and James, A. (2008). *European Childhoods: Cultures, Politics and Childhoods in Europe: Cultures, Politics and Childhoods in the European Union*. Basingstoke, England; New York, Palgrave Schol. Print UK.
- James, A., Jenks, C. and Prout, A. (1998). *Theorizing childhood*. Cambridge, UK, Polity Press in association with Blackwell Publishers Ltd.
- James, A. and Prout, A. (1997). *Constructing and reconstructing childhood: contemporary issues in the sociological study of childhood*. London; Washington, D.C., Falmer Press.
- Jaque, J. M. and Rodríguez, F. (2011, June 4). *Los 20 años de la generación Ritalín*. La Tercera. Available from: <http://www.sopnia.com/archivos/2011/LaTerceraJunio.pdf>
- Jenkins, J. H. (2011). *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology* (1st edition). Santa Fe, N.M., SAR Press.
- Jenks, C. (2005). *Childhood: Second edition* (2nd edition). Abingdon, Oxon; New York, Routledge.
- JUNAEB. [no date]. "*Habilidades Para la Vida*". Retrieved 15 August, 2014, from <http://www.junaeb.cl/habilidades-para-la-vida>
- Kraftl, P. (2013). Beyond "voice", beyond "agency", beyond "politics"? Hybrid childhoods and some critical reflections on children's emotional geographies. *Emotion, Space and Society*, **9**: 13–23. <https://doi.org/10.1016/j.emospa.2013.01.004>
- Lakoff, A. (2000). Adaptive will: the evolution of attention deficit disorder. *Journal of the History of the Behavioral Sciences*, **36**(2): 149–169.
- Lakoff, A. (2005). *Pharmaceutical reason: medication and psychiatric knowledge in Argentina*. Cambridge, Cambridge University Press.
- Lancy, D. (2012). Unmasking Children's Agency. *AnthropoChildren*. **2** [no pages]. Retrieved 5 January, 2017, from <http://popups.ulg.ac.be/2034-8517/index.php?id=1253>
- Larraín, S. and Bascuñan, C. (2012). "*4to estudio de maltrato infantil*". UNICEF. Retrieved from http://www.unicef.cl/unicef/public/archivos_documento/382/maltrato%20infantil.pdf
- Latour, B. (2007). *Reassembling the Social: An Introduction to Actor-Network-Theory* (New edition). Oxford, Oxford University Press, USA.

- Latour, B. (2013). *Des sujets récalcitrants*. [Online]. OpenEdition. Available from: <https://doi.org/urn:doi:10.4000/books.pressessmines.204>
- Law, J. and Mol, A. (1995). Notes on materiality and sociality. *The Sociological Review*, **43**(2): 274–294. <https://doi.org/10.1111/j.1467-954X.1995.tb00604.x>
- LeCompte, M. D. and Goetz, J. P. (1984). *Ethnography and Qualitative Design in Educational Research*. Orlando, Fla., Academic Press Inc.
- Lee, N. (2001). *Childhood and society: growing up in an age of uncertainty*. Buckingham, Open University Press.
- Lee, N. (2005). *Childhood and Human Value: Development, Separation and Separability*. Maidenhead; New York, Open University Press.
- Lee, N. and Brown, S. (1994). Otherness and the Actor Network: The Undiscovered Continent. *American Behavioral Scientist*, **37**(6): 772–790. <https://doi.org/10.1177/0002764294037006005>
- Lee, N. and Motzkau, J. (2011). Navigating the bio-politics of childhood. *Childhood*, **18**(1): 7–19. <https://doi.org/10.1177/0907568210371526>
- Lemke, T. (2002). Foucault, Governmentality, and Critique. *Rethinking Marxism*, **14**(3): 49–64. <https://doi.org/10.1080/089356902101242288>
- Lock, M. and Nguyen, V.-K. (2010). *An Anthropology of Biomedicine* (1st edition). Chichester, West Sussex; Malden, MA, Wiley-Blackwell.
- Madrid, S. (2016). “*Diversidad sin diversidad*”: Los colegios particulares pagados de elite y la formación de la clase dominante en una sociedad de mercado. In *Mercado escolar y oportunidad escolar: libertad, diversidad y desigualdad* (Colección Estudios en Educación). J. Corvalán, A. Carrasco, & J. E. García-Huidobro (Eds.). Santiago, Ediciones UC.
- Macdonald, H., & Loder, E. (2015). Too much medicine: the challenge of finding common ground. *BMJ*, **350**. <https://doi.org/10.1136/bmj.h1163>
- Mahmood, S. (2001). Feminist Theory, Embodiment, and the Docile Agent: Some Reflections on the Egyptian Islamic Revival. *Cultural Anthropology*, **16**(2): 202–236. <https://doi.org/10.1525/can.2001.16.2.202>

- Malacrida, C. (2004). Medicalization, Ambivalence and Social Control: Mothers' Descriptions of Educators and ADD/ADHD. *Health*, **8**(1): 61–80. <https://doi.org/10.1177/1363459304038795>
- Manzo, L., & Westerhout, C. (2003). El Proyecto Educativo Institucional. *Cuadernos Interculturales*, **1**(1): 9.
- Martin, E. (2006). The Pharmaceutical Person. *BioSocieties*, **1**(3): 273–287. <https://doi.org/10.1017/S1745855206003012>
- Martin, E. (2009). *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton University Press.
- Mayall, B. (2002). *Towards a sociology for childhood: thinking from children's lives*. Buckingham; Philadelphia, Open University Press.
- Mayes, R., Bagwell, C. and Erkulwater, J. L. (2009). *Medicating children: ADHD and pediatric mental health*. Cambridge, Mass., Harvard University Press.
- Mikkelsen, M. R. and Christensen, P. (2009). Is Children's Independent Mobility Really Independent? A Study of Children's Mobility Combining Ethnography and GPS/Mobile Phone Technologies. *Mobilities*, **4**(1): 37–58. <https://doi.org/10.1080/17450100802657954>
- Mills, C. (2014). Psychotropic Childhoods: Global Mental Health and Pharmaceutical Children. *Children & Society*, **28**(3): 194–204. <https://doi.org/10.1111/chso.12062>
- Milstein, D. and Mendes. (2017). *La escuela en el cuerpo: Estudios sobre el orden escolar y la construcción social de los alumnos en escuelas primarias* (2da Edición). Buenos Aires, Miño y Dávila Editores.
- Ministerio de Educación. (2009). “Decreto 170. Decreto con toma de razón N° 170. Fija normas para determinar los alumnos con necesidades educativas especiales que serán beneficiarios de las subvenciones para educación especial”. Retrieved from <http://www.leychile.cl/Navegar?idNorma=1012570>
- Ministerio de Educacion (MINEDUC). (2009). “Déficit Atencional: Guía para su comprensión y desarrollo de estrategias de apoyo, desde un enfoque inclusivo, en el nivel de Educación Básica”. Retrieved from http://www.mineduc.cl/usuarios/edu.especial/doc/201305151612430.Deficit_Atencional.pdf

- Ministerio de Salud (MINSAL). (2008). *Guía clínica Atención Integral de Niñas/ Niños y Adolescentes con Trastorno Hipercinético/Trastorno de la Atención (THA)*. MINSAL.
- Mol, A. (2002). *The body multiple: ontology in medical practice*. Durham, N.C., Duke University Press.
- Montecino, S. (1991). *Madres y huachos: alegorías del mestizaje chileno*. Santiago, Editorial Cuarto Propio-CEDEM.
- Montenegro, H. (1983a, October 11). *El niño difícil*. Revista YA.
- Montenegro, H. (1983b, November 1). *Disfunción cerebral y relación padres-hijos*. Revista YA.
- Mount Sinai and Bethlehem. (1999). *El tipo de Hombre que nuestros Colegios quieren formar*.
- Mount Sinai and Bethlehem. (2015). *Manual de Convivencia Escolar*.
- Mount Sinai and Bethlehem. (2016). *Nuestro proyecto educativo*.
- Moya Díaz, E. and Hernández Aracena, J. (2014). El Rol de los Colegios de Elite en la Reproducción intergeneracional de la Elite Chilena. *Revista Austral de Ciencias Sociales*, **26**: 59–82. <https://doi.org/10.4206/rev.austral.cienc.soc.2014.n26-04>
- Mueller, A. K., Fuermaier, A. B. M., Koerts, J. and Tucha, L. (2012). Stigma in attention deficit hyperactivity disorder. *Attention Deficit and Hyperactivity Disorders*, **4**(3): 101–114. <https://doi.org/10.1007/s12402-012-0085-3>
- Murris, K. (2016). *The Posthuman Child: Educational transformation through philosophy with picturebooks* (1st edition). London; New York, NY, Routledge.
- National Institute of Mental Health. (2012). “*Attention Deficit Hyperactivity Disorder (ADHD)*”. Retrieved 19 May, 2014, from http://www.nimh.nih.gov/health/publications/attention-deficit-hyperactivity-disorder/adhd_booklet_cl508.pdf
- Naughton, G. M. (2005). *Doing Foucault in Early Childhood Studies: Applying Post-Structural Ideas* (New edition). London; New York, Routledge.
- Nuffield Council on Bioethics. (2015). “*Naturalness. Ideas about naturalness in public and political debates about science, technology and medicine*”. Retrieved from <http://nuffieldbioethics.org/project/naturalness/the-findings/>

Nye, R. A. (2003). The evolution of the concept of medicalization in the late twentieth century. *Journal of the History of the Behavioral Sciences*, **39**(2): 115–129.

<https://doi.org/10.1002/jhbs.10108>

Observatorio Chileno de Políticas Educativas. “Mensaje de s.e. el Presidente de la República con el que se inicia un proyecto de ley que establece una subvención escolar preferencial para niños y niñas socio-económicamente vulnerables”. [Online]. Observatorio Chileno de Políticas

Educativas. Retrieved from:

http://www.opech.cl/legislativo/debate_legislativo/2007_Proyectos/proy5768-Tramitacion-Ingreso%20proy4424%2002-11-2005.pdf

Ortega, F. (2014). *Corporeality, Medical Technologies and Contemporary Culture*. New York, NY, Routledge.

Oswell, D. (2012). *The Agency of Children: From Family to Global Human Rights*. New York, Cambridge University Press.

Parens, E. (2013). On Good and Bad Forms of Medicalization. *Bioethics*, **27**(1): 28–35.

<https://doi.org/10.1111/j.1467-8519.2011.01885.x>

Parens, E. and Johnston, J. (2009). Facts, values, and attention-deficit hyperactivity disorder (ADHD): an update on the controversies. *Child and Adolescent Psychiatry and Mental Health*, **3**(1): 1. <https://doi.org/10.1186/1753-2000-3-1>

Parker, I., Georgaca, E., Harper, D., McLaughlin, T. and Stowell-Smith, M. (Eds.). (1995). *Deconstructing Psychopathology*. London; California, SAGE Publications.

Petryna, A., Lakoff, A. and Kleinman, A. (Eds.). (2006). *Global Pharmaceuticals: Ethics, Markets, Practices*. Durham, NC; London, Duke University Press. Retrieved from https://www.amazon.co.uk/Global-Pharmaceuticals-Ethics-Markets-Practices/dp/082233741X/ref=sr_1_1?ie=UTF8&qid=1509551082&sr=8-1&keywords=global+pharmaceuticals

Phillips, J. (2006). Agencement/Assemblage. *Theory, Culture & Society*, **23**(2-3): 108-109. <https://doi.org/10.1177/026327640602300219>

Pickering, A. (1995). *The Mangle of Practice: Time, Agency, and Science* (1st edition). Chicago, University of Chicago Press.

Pickering, A. (2001). *Practice and posthumanism: Social theory and a history of agency*. In *The practice turn in contemporary theory* (1st edition). London; New York, Routledge.

Pickering, A. (2013). Being in an environment: a performative perspective. *Natures Sciences Sociétés*, **21**(1): 77–83. <https://doi.org/10.1051/nss/2013067>

Pinter, A. and Zandian, S. (2014). ‘I don’t ever want to leave this room’: benefits of researching “with” children. *ELT Journal*, **68**(1): 64–74. <https://doi.org/10.1093/elt/cct057>

Polanczyk, G., de Lima, M. S., Horta, B. L., Biederman, J. and Rohde, L. A. (2007). The worldwide prevalence of ADHD: a systematic review and metaregression analysis. *The American Journal of Psychiatry*, **164**(6): 942–948. <https://doi.org/10.1176/appi.ajp.164.6.942>

Programa de las Naciones Unidas para el Desarrollo (PNUD). (2014). “*El poder: ¿para qué y para quién? Programa de las Naciones Unidas para el Desarrollo*”. Retrieved from <http://desarrollohumano.cl/idh/informes/2004-el-poder-para-que-y-para-quien/>

Prout, A. (1996). Actor-network theory, technology and medical sociology: an illustrative analysis of the metered dose inhaler. *Sociology of Health & Illness*, **18**(2): 198–219. <https://doi.org/10.1111/1467-9566.ep10934726>

Prout, A. (2005). *The Future of childhood*. London; New York, RoutledgeFalmer.

Prout, A. (2011). Taking a Step Away from Modernity: reconsidering the new sociology of childhood. *Global Studies of Childhood*, **1**(1): 4. <https://doi.org/10.2304/gsch.2011.1.1.4>

Prout, A. and James, A. (1990). *A new paradigm for the sociology of childhood? Provenance, promise and problems*. In *Constructing and reconstructing childhood: contemporary issues in the sociological study of childhood*. A. James and A. Prout (Eds.). London, The Falmer Press.

Punch, S. and McIntosh, I. (2014). “Food is a funny thing within residential child care”: Intergenerational relationships and food practices in residential care. *Childhood*, **21**(1): 72–86. <https://doi.org/10.1177/0907568213481814>

Rabinow, P. (1996). *Essays on the Anthropology of Reason* (First Printing, Underlining edition). Princeton, N.J., Princeton University Press.

Radcliffe, N. and Newnes, C. (Eds.). (2005). *Making and Breaking Children’s Lives*. Ross-on-Wye, UK, PCCS Books.

Radcliffe, N. and Timimi, S. (2005). *The Rise and rise of ADHD*. In *Making and breaking children's lives*. C. Newnes and N. Radcliffe (Eds.). Ross-on-Wye, PCCS Books.

Rafalovich, A. (2008). *Framing ADHD children: a critical examination of the history, discourse, and everyday experience of attention deficit/hyperactivity disorder*. Lanham, Md., Lexington Books.

Rafalovich, A. (2013). Attention Deficit-Hyperactivity Disorder as the Medicalization of Childhood: Challenges from and for Sociology. *Sociology Compass*, 7(5): 343–354.
<https://doi.org/10.1111/soc4.12034>

Ramírez, L. (2013). *Estudio muestra que Ritalin no mejora el rendimiento académico*. [Online]. La Tercera. Available from: <http://www.latercera.com/noticia/tendencias/2013/06/659-528966-9-estudio-muestra-que--ritalin-no-mejora-el-rendimiento-academico.shtml> [Accessed 28 March, 2014].

Retamal, J. (2013). *Pobres niños ricos: las claves de los colegios de elite*. [Online]. El Mostrador. Available from: <http://www.elmostrador.cl/noticias/opinion/2013/06/05/pobres-ninos-ricos-las-claves-de-los-colegios-de-elite/> [Accessed 22 March, 2017]

Roizblatt, A., Bustamante, F. and Bacigalupo, F. (2003). Trastorno por déficit atencional con hiperactividad en adultos. *Revista Médica de Chile*, 131(10): 1195–1201.
<https://doi.org/10.4067/S0034-98872003001000015>

Rojas, J. (2010). *Historia de la infancia en el Chile republicano: 1810-2010*. Santiago, OchoLibros.

Rojas Navarro, S. and Rojas, P. (2015). *The making of children identities beyond adult given classifications: Biomedical diagnostic categories and processes of resistance performed by Chilean children*. In *Dialogue and Debate in the Making of Theoretical Psychology*. J. Cresswell, A. Hayé, A. Larraín, M. Morgan and G. Sullivan (Eds.). Ontario, Captus Press.

Rojas Navarro, S., Rojas, P., & Peña, M. (2017). From problematic children to problematic diagnosis: The paradoxical trajectories of ADHD in Chile. In *Global Perspectives on ADHD: Social Dimensions of Diagnosis and Treatment in 16 Countries*. Baltimore, Johns Hopkins University Press.

Rose, N. (1985). *The psychological complex: psychology, politics, and society in England, 1869-1939*. London; Boston, Routledge & Kegan Paul.

- Rose, N. (1988). Calculable minds and manageable individuals. *History of the Human Sciences*, **1**(2): 179–200. <https://doi.org/10.1177/095269518800100202>
- Rose, N. (1998). *Governing the Soul: Shaping of the Private Self* (Reprint edition). Cambridge University Press.
- Rose, N. (2003). Neurochemical selves. *Society*, **41**(1): 46–59. <https://doi.org/10.1007/BF02688204>
- Rose, N. (2006a). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, N.J., Princeton University Press.
- Rose, N. (2006b). Disorders Without Borders? The Expanding Scope of Psychiatric Practice. *BioSocieties*, **1**(4), 465–484. <https://doi.org/10.1017/S1745855206004078>
- Rose, N. (2007). Beyond medicalisation. *Lancet*, **369**(9562): 700–702. [https://doi.org/10.1016/S0140-6736\(07\)60319-5](https://doi.org/10.1016/S0140-6736(07)60319-5)
- Rose, N. (2013). The Human Sciences in a Biological Age. *Theory, Culture & Society*, **30**(1): 3–34. <https://doi.org/10.1177/0263276412456569>
- Rose, N. and Abi-Rached. (2013). *Neuro: The new brain sciences and the management of the mind*. Oxfordshire; Princeton, N.J., Princeton University Press.
- Rose, N. and Novas, C. (2008). *Biological Citizenship*. In *Global Assemblages* (pp. 439–463). A. Ong and S. J. Collier (Eds.). [Online]. Blackwell Publishing Ltd. Available from: <http://onlinelibrary.wiley.com/doi/10.1002/9780470696569.ch23/summary>
- Rosenmann, L. (2010, May 23). *Quinto básico, el año más complicado para los escolares*. [Online] La Tercera. Available from http://www.latercera.com/contenido/679_261898_9.shtml
- Ruiz, A. (1985, June 25). *Niños inquietos*. Revista YA.
- Ruiz-Tagle, J. and López M, E. (2014). El estudio de la segregación residencial en Santiago de Chile: revisión crítica de algunos problemas metodológicos y conceptuales. *EURE (Santiago)*, **40**(119): 25–48. <https://doi.org/10.4067/S0250-71612014000100002>
- Ryan, K. W. (2012). The new wave of childhood studies: Breaking the grip of bio-social dualism? *Childhood*, **19**(4): 439–452. <https://doi.org/10.1177/0907568211427612>

- Sabatini, F. and Brain, I. (2008). La segregación, los guetos y la integración social urbana: mitos y claves. *EURE (Santiago)*, **34**(103): 5–26. <https://doi.org/10.4067/S0250-71612008000300001>
- Sabatini, F., Cáceres, G. and Cerda, J. (2001). Segregación residencial en las principales ciudades chilenas: Tendencias de las tres últimas décadas y posibles cursos de acción. *EURE (Santiago)*, **27**(82): 21–42. <https://doi.org/10.4067/S0250-71612001008200002>
- Sadler, J. Z., Jotterand, F., Lee, S. C. and Inrig, S. (2009). Can medicalization be good? Situating medicalization within bioethics. *Theoretical Medicine and Bioethics*, **30**(6): 411–425. <https://doi.org/10.1007/s11017-009-9122-4>
- Salazar, G. (2007). *Ser niño “huacho” en la historia de Chile (Siglo XIX)*. LOM.
- Salazar, S. (2006). “Estilos de crianza y cuidado infantil en Santiago de Chile. Algunas reflexiones para comprender la violencia educativa en la familia”. Asociación Chilena Pro Naciones Unidas, Achnu. Retrieved from <http://resourcecentre.savethechildren.se/library/estilos-de-crianza-y-cuidado-infantil-en-santiago-de-chile-algunas-reflexiones-para>
- Santos, B. de S. (2001). Nuestra America: Reinventing a Subaltern Paradigm of Recognition and Redistribution. *Theory, Culture & Society*, **18**(2–3): 185–217. <https://doi.org/10.1177/02632760122051706>
- Savransky, M. (2014). Of Recalcitrant Subjects. *Culture, Theory and Critique*, **55**(1): 96–113. <https://doi.org/10.1080/14735784.2013.821767>
- Schatzki, T. R., Knorr-Cetina, K. and Savigny, E. von. (2001). *The Practice Turn in Contemporary Theory*. Abingdon, Oxon; New York, Psychology Press.
- Schwarz, A. and Cohen, S. (2013, March 31). *More Diagnoses of A.D.H.D. Causing Concern*. [Online]. The New York Times. Available from <http://www.nytimes.com/2013/04/01/health/more-diagnoses-of-hyperactivity-causing-concern.html>
- Scott, S. (2009). *Making Sense of Everyday Life*. Cambridge, UK; Malden, MA, Polity Press.
- Serra, C. (2004). Etnografía escolar, etnografía de la educación. *Revista de Educación*, (334): 165–176.
- Sharpe, K. (2014). Medication: The smart-pill oversell. *Nature News*, **506**(7487): 146.

<https://doi.org/10.1038/506146a>

Shaw, C., Brady, L.-M. and Davey, C. [2011]. "Guidelines for research with children and young people". Retrieved 29 October, 2014, from <http://www.participationworks.org.uk/resources/guidelines-for-research-with-children-and-young-people>

Singh, I. (2002). Bad Boys, Good Mothers, and the Miracle of Ritalin. *Science in Context*, **15**(4): 577–603.

Singh, I. (2005). Will the “Real Boy” Please Behave: Dosing Dilemmas for Parents of Boys with ADHD. *The American Journal of Bioethics*, **5**(3): 34–47.
<https://doi.org/10.1080/15265160590945129>

Singh, I. (2007a). Capacity and competence in children as research participants. Researchers have been reluctant to include children in health research on the basis of potentially naive assumptions. *EMBO Reports*, *8 Spec No*, S35–39. <https://doi.org/10.1038/sj.embor.7401018>

Singh, I. (2007b). Clinical implications of ethical concepts: moral self-understandings in children taking methylphenidate for ADHD. *Clinical Child Psychology and Psychiatry*, **12**(2): 167–182.

Singh, I. (2007c). Clinical Implications of Ethical Concepts: Moral Self-Understandings in Children Taking Methylphenidate for ADHD. *Clinical Child Psychology and Psychiatry*, **12**(2): 167–182.
<https://doi.org/10.1177/1359104507075920>

Singh, I. (2008). Beyond polemics: science and ethics of ADHD. *Nature Reviews Neuroscience*, **9**(12): 957–964. <https://doi.org/10.1038/nrn2514>

Singh, I. (2011). A disorder of anger and aggression: Children’s perspectives on attention deficit/hyperactivity disorder in the UK. *Social Science & Medicine (1982)*, **73**(6): 889–896.
<https://doi.org/10.1016/j.socscimed.2011.03.049>

Singh, I. (2012). Not robots: children’s perspectives on authenticity, moral agency and stimulant drug treatments. *Journal of Medical Ethics*. <https://doi.org/10.1136/medethics-2011-100224>

Singh, I. (2013a). Brain talk: power and negotiation in children’s discourse about self, brain and behaviour. *Sociology of Health & Illness*, **35**(6): 813–827. <https://doi.org/10.1111/j.1467-9566.2012.01531.x>

Singh, I. (2013b). Victimology versus character: new perspectives on the use of stimulant drugs in children. *Journal of Medical Ethics*, 39(6): 372–373. <https://doi.org/10.1136/medethics-2012-101283>

Singh, I., Kendall, T., Taylor, C., Mears, A., Hollis, C., Batty, M. and Keenan, S. (2010). Young People's Experience of ADHD and Stimulant Medication: A Qualitative Study for the NICE Guideline. *Child and Adolescent Mental Health*, 15(4): 186–192. <https://doi.org/10.1111/j.1475-3588.2010.00565.x>

Singh, I. and Wessely, S. (2015). Childhood: a suitable case for treatment? *The Lancet Psychiatry*, 2(7): 661–666. [https://doi.org/10.1016/S2215-0366\(15\)00106-6](https://doi.org/10.1016/S2215-0366(15)00106-6)

Stengers, I. (2010). *Cosmopolitics I*. Minneapolis, University of Minnesota Press.

Szasz, T. (1960). The myth of mental illness. *American Psychologist*, 15(2): 113–118. <https://doi.org/10.1037/h0046535>

Szasz, T. (1984). *The Myth of Mental Illness*. New York, HarperCollins.

Taussig, K.-S., Hoeyer, K. and Helmreich, S. (2013). The Anthropology of Potentiality in Biomedicine: An Introduction to Supplement 7. *Current Anthropology*, 54(S7): S3–S14. <https://doi.org/10.1086/671401>

Taylor, A. (2013). *Reconfiguring the Natures of Childhood* (1st Edition). Milton Park, Abingdon, Oxon, Routledge.

Taylor, A. and Blaise, M. (2014). Queer worlding childhood. *Discourse: Studies in the Cultural Politics of Education*, 35(3): 377–392. <https://doi.org/10.1080/01596306.2014.888842>

Thompson, C. (2005). *Making parents: the ontological choreography of reproductive technologies*. Cambridge, MA, MIT Press.

Thompson, C. (2013). *Good Science: The Ethical Choreography of Stem Cell Research*. Cambridge, Massachusetts; London, England, The MIT Press.

Thumala, M. A. (2007). *Riqueza y piedad: el catolicismo de la élite económica chilena*. Buenos Aires, Debate.

Thumala, M. A. (2011). *Distinción de base religiosa en la elite económica chilena: algunas*

limitaciones en el enfoque de Bordieu. In Notables, tecnócratas y mandarines. Elementos de sociología de las Elites en Chile, 1990-2010. A. Joignant and P. Guell (Eds.). Ediciones UDP.

Thumala Olave, M. A. (2010). The richness of ordinary life: Religious justification among Chile's business elite. *Religion*, **40**(1): 14–26. <https://doi.org/10.1016/j.religion.2009.04.011>

Thumala Olave, M. A. (2012). The aristocracy of the will: a critique of Pierre Bourdieu with illustrations from Chile. *Social Compass*, **59**(1): 52–68.
<https://doi.org/10.1177/0037768611432126>

Timimi, S. (2002). *Pathological Child Psychiatry and the Medicalization of Childhood*. Psychology Press.

Timimi, S. et al. (2004). A critique of the international consensus statement on ADHD. *Clinical Child and Family Psychology Review*, **7**(1): 59–69.

Timimi, S. and Taylor, E. (2004). ADHD is best understood as a cultural construct. *The British Journal of Psychiatry*, **184**(1): 8–9. <https://doi.org/10.1192/bjp.JaninDeb>

Tisdall, E. K. M. and Punch, S. (2012). Not so “new”? Looking critically at childhood studies. *Children's Geographies*, **10**(3): 249–264. <https://doi.org/10.1080/14733285.2012.693376>

Torres, A. M. (2013). Estudio de los proyectos de integración escolar de primer año de Educación Básica en establecimientos municipales y particulares subvencionados de la provincia de Valparaíso. *Perspectiva Educacional*, **52**(1): 124–146. <https://doi.org/10.4151/07189729>

Uprichard, E. (2008). Children as “Being and Becomings”: Children, Childhood and Temporality. *Children & Society*, **22**(4): 303–313. <https://doi.org/10.1111/j.1099-0860.2007.00110.x>

Urzua, A., Domic, M., Cerda, A., Ramos, M. and Quiroz, J. (2009). Trastorno por Déficit de Atención con Hiperactividad en Niños Escolarizados. *Revista Chilena de Pediatría*, **80**(4): 332–338. <https://doi.org/10.4067/S0370-41062009000400004>

Valdés Subercaseaux, X. (2008). *Notas sobre la metamorfosis de la familia en Chile*. In *Niñ@s y jóvenes en el Chile de hoy: su lugar en los nuevos contextos familiares*. Santiago, Facultad de ciencias humanas y educación, Universidad Diego Portales.

Valenzuela, J. P., Bellei, C. and Ríos, D. de los. (2014). Socioeconomic school segregation in a market-oriented educational system. The case of Chile. *Journal of Education Policy*, **29**(2): 217–

241. <https://doi.org/10.1080/02680939.2013.806995>

van der Geest, S. and Whyte, S. R. (1989). The Charm of Medicines: Metaphors and Metonyms. *Medical Anthropology Quarterly*, **3**(4): 345–367.

<https://doi.org/10.1525/maq.1989.3.4.02a00030>

van der Geest, S. (1996). *Grasping the Children's Point of View? An Anthropological Reflection*. In, *Children, Medicines, and Culture*. P. J. Bush, D. J. Trakas, E. J. Sanz, R. L. Wirsing, T. Vaskilampi, and A. Prout (Eds.). New York, Pharmaceutical Products Press/Haworth Press.

van der Geest, S., Whyte, S. R. and Hardon, A. (1996). The anthropology of pharmaceuticals: A Biographical Approach. *Annual Review of Anthropology*, **25**(1): 153–178.

<https://doi.org/10.1146/annurev.anthro.25.1.153>

Velasco, E. (2010). *Inclusion Criteria*. In *Encyclopedia of Research Design*. [Online]. Thousand Oaks, California: SAGE Publications, Inc. Available from:

<http://knowledge.sagepub.com/view/researchdesign/n183.xml>

Vergara, A. (1999). Infancia y vida cotidiana: un recorrido inicial. *Praxis*, **1**.

Vergara, A. (2014a). Public policy discourses on childhood during Chilean post-authoritarian democracy: A case of discursive colonization by the language of the free market. *Childhood*,

<https://doi.org/10.1177/0907568214549079>

Vergara, A. (2014b). The Cultural Politics of Childhood: Public Policies in Post-authoritarian Chile. *Children & Society*, **29**(4): 288-298. <https://doi.org/10.1111/chso.12040>

Vergara, A. and Bustos, J. (2003). *Esa oscura vida radiante: juventud, infancia y nuevas identidades culturales*. Santiago, Ediciones Escaparte.

Vergara, A., Vergara, E., Peña, M. and Chávez, P. (2014). Childhood in Children's Eyes: Analysis of a Discourse among Middle-Income Sectors in Santiago, Chile. *Children & Society*, **28**(2): 81–92.

<https://doi.org/10.1111/j.1099-0860.2012.00446.x>

Vicente, B., Saldivia, S., Barra, F. D. la, Melipillan, R., Valdivia, M. and Kohn, R. (2012). Salud Mental infanto-juvenil en Chile y brechas de atención Sanitarias. *Revista Médica de Chile*, **140**(4): 447-457. <http://www.revistamedicadechile.cl/ojs/index.php/rmedica/article/view/1681>

Vidal, F. and Ortega, F. (2017). *Being Brains: Making the Cerebral Subject* (1 edition). New York,

NY, Fordham University Press.

Vrecko, S. (2009). Therapeutic Justice in Drug Courts: Crime, Punishment and Societies of Control. *Science as Culture*, **18**(2): 217–232. <https://doi.org/10.1080/09505430902885623>

Vrecko, S. (2010). “Civilizing technologies” and the control of deviance. *BioSocieties*, **5**(1): 36–51. <https://doi.org/10.1057/biosoc.2009.8>

Vrecko, S. (2013). Just How Cognitive Is “Cognitive Enhancement”? On the Significance of Emotions in University Students’ Experiences with Study Drugs. *AJOB Neuroscience*, **4**(1): 4–12. <https://doi.org/10.1080/21507740.2012.740141>

Wall, J. (2010). *Ethics in Light Of Childhood* (First edition). Washington, D.C, Georgetown University Press.

Waterston, A. (2014, March). “*The Social Life of Health, Illness, Medicine and Health Care: Anthropological Views*”. Retrieved 12 March, 2017, from <http://www.americananthro.org/StayInformed/OAIssueTOC.aspx?ItemNumber=2499>

Whyte, S. R. and van der Geest, S. (1994). Injections: Issues and Methods for Anthropological Research. In *Medicines: Meanings and contexts*. N. L. Etkin and M. Tan (Eds.) Quezon City, Health Action Information Network HAIN.

Wilens, T. E., Adler, L. A., Adams, J., Sgambati, S., Rotrosen, J., Sawtelle, R., Utzinger, L. and Fusillo, S. (2008). Misuse and Diversion of Stimulants Prescribed for ADHD: A Systematic Review of the Literature. *Journal of the American Academy of Child & Adolescent Psychiatry*, **47**(1): 21–31. <https://doi.org/10.1097/chi.0b013e31815a56f1>

World Health Organization. (2004). “*Global School-based Student Health Survey Chile questionnaire*”. World Health Organization. Retrieved from http://www.who.int/chp/gshs/Chile_questionnaire_english_2004.pdf?ua=1

Wyness, M. G. (1999). Childhood, Agency and Education Reform. *Childhood*, **6**(3): 353–368. <https://doi.org/10.1177/0907568299006003004>

Yañez, C. (2014, March 16). *El doctor que dice que el déficit atencional no existe*. [Online]. La Tercera. Available from: <http://www.latercera.com/noticia/tendencias/2014/03/659-569733-9-el-doctor-que-dice-que-el-deficit-atencional-no-existe.shtml> [Accessed 25 June, 2014]

Zimmerman, S. D. (2016). *Making the One Percent: The Role of Elite Universities and Elite Peers* (Working Paper No. 22900). National Bureau of Economic Research. Available from:
<https://doi.org/10.3386/w22900>

Zola, I. K. (1972). Medicine as an Institution of Social Control. *The Sociological Review*, **20**(4): 487–504. <https://doi.org/10.1111/j.1467-954X.1972.tb00220.x>